



**PLEASE RETURN TO:**

**WINTER** (September 1 - May 1)  
P.O. Box 880449, Boca Raton, FL 33488  
p: 800-494-6238 f: 561-883-6490

**SUMMER** (May 1 - August 31)  
700 Churchill Street, Pittsfield, MA 01201  
p: 413-447-8900 / 800-494-6238  
f: 413-447-8905

Camper(s) Name \_\_\_\_\_

First, Last (Please Print)

## **AUTHORIZATION FOR COMMUNICATION WITH MEDICAL PERSONNEL**

I \_\_\_\_\_, parent or guardian of the above named camper, authorize any physician, nurse or other health care provider to communicate with the medical staff and directors of Camp Winadu, or their designees, about my child's medical condition, treatment and/or prognosis.

I further authorize the medical staff of Camp Winadu to discuss any medical conditions with the directors, their designees, or my child's counselors when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.

These authorizations are limited to June 20, 2009 through August 15, 2009.

## **AUTHORIZATION FOR ADMINISTERING OVER THE COUNTER MEDICATION**

I give permission for Camp Winadu to administer the following over the counter medications if the infirmary staff deems it necessary. Dosages will be administered according to the directions on the bottle unless a physician directs otherwise.

- Tylenol • Pepto Bismol / Mylanta • Cough / Cold Medications (e.g. Sudafed / Benadryl) • Immodium AD
- Topical Preparations (e.g. Calamine / Cortaid)

I give permission to the medical personnel to provide routine health care to administer medications, to order X-rays, routine tests, treatments and to release any records necessary.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment including hospitalization for my child. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed Parent Name \_\_\_\_\_ Phone \_\_\_\_\_