

KODA Camp Ohio

The Only Deaf-Owned and Operated KODA Camp in Ohio

Medical Release Form

Camper's Name: _____

Please list 2 people who could be reached in case of an Emergency:

1. _____ Relationship: _____

Text: _____ Phone: _____ VP or Voice?

2. _____ Relationship: _____

Text: _____ Phone: _____ VP or Voice?

Medical Information:

Family Physician or Medical Office: _____

Address: _____

Phone: _____

Please check the health issues your child has:

Heart ___ Diabetes ___ Epilepsy ___ Other? _____

Allergies (please list or indicate if none): _____

Medications? No ___ Yes ___

Medicine Name	For what condition?	Dosage	How often/When?

Name of your health insurance company: _____

Policy number: _____ Phone number: _____

I, _____, declare that I am the parent/legal guardian of (put child's name) _____ and I give my permission to the Interpreters of the Deaf, LLC and KODA Camp Ohio staff to provide or access treatment for my child in the event of a medical emergency .

Signature/Date

Relationship to child



KODA Camp Ohio is a registered trademark of Interpreters of the Deaf, LLC