

**Counselor Registration
and Medical Release
Junior Camp 2009**

Must be filled out and returned to Danna Jones by June 30th, 2009

Name: _____ Male: _____ Female: _____
Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Church: _____
First Emergency Contact Person: _____
Home Phone: _____ Cell: _____
Second Emergency Contact Person: _____
Home Phone: _____ Cell: _____

Medical Release Form

I, _____ hereby release PNA, together with its agents and employees, from all actions, cause of actions, damages, claims or demands which I, my heirs, executors, administrators or assigns may have against the PNA and/or the above described parties for all personal injuries known or unknown which I have or may incur by participating in the above activity.

I, the undersigned, have read this release and understand all of its terms. I execute it voluntarily and with all knowledge of its significance.

I hereby authorize PNA and/or its employees and agents to consent to the administration of any treatment deemed necessary by a licensed physician, surgeon, or dentist; and/or transfer to any hospital reasonably accessible. I acknowledge the PNA and/or its employees and agents may authorize such treatment and/or transfer at their sole discretion. PNA and /or employees and agents shall make a reasonable attempt to contact participant's parent before consenting to any treatment unless an emergency requiring immediate treatment exists.

I further promise to hold harmless PNA and/or its employees and agents from any and all expense incurred pursuant to this authorization in obtaining medical treatment and/or physician's charges.

The following information is needed by any hospital or practitioner not having access to you medical history:

Allergies: _____
Medication being taken: _____
Date of last tetanus shot: _____
Physical Impairments: _____
Other pertinent facts to which physician should be alerted: _____

Below I give my Release Authorization in accordance with the above statements:

Date: _____

Signature: _____

Insurance Provider: _____

Group# / Cert. #: _____

Insurance Phone #: _____