

Counselor Medical Information

Surgical Authorization (Limited Purpose Power of Attorney)

The undersigned parent(s) hereby appoint the Camp Sunshine Executive Director (or in her absence another competent adult representative of Camp Sunshine) as our attorney-in-fact and delegate to such person(s) the power to consent on our behalf to any and all routine medical and surgical treatment or care of our child determined to be necessary or desirable by my/our child's attending nurse(s) and/or physician(s). This Power of Attorney shall not, however, be effective for consent to non-emergency elective surgery.

The undersigned parent(s) hereby consent generally to any and all routine medical or surgical treatment or care of my/our child determined to be necessary or desirable by any nurse and/or physician attending my/our child except non-emergency elective surgery or care or treatment expressly excluded above. The undersigned hereby ratify and affirm any and all consent given by our attorney-in-fact pursuant to this Power of Attorney.

This Power of Attorney shall be in effect throughout the Camp Sunshine camping program operated during the month of August 2012, unless earlier revoked by the undersigned. Any nurse, physician or hospital may assume and rely that this authorization is currently in effect during such period unless notified in writing to the contrary.

The undersigned parent(s) certify that they have read this Power of Attorney (or had it read to them) and that they understand this Power of Attorney.

Name of Counselor: _____
(Print)

Signature of Counselor: _____ Date: _____

Signature of Counselor's Parent / Legal Guardian: _____ Date: _____

Parent Signature needed if under 18.

Signature of Counselor's Parent / Legal Guardian: _____ Date: _____

(If two parents, both must sign):

****Instructions ONLY** for those who prefer to submit this registration electronically. By typing your name on the above signature line, you acknowledge the accuracy, and accept and approve the terms of this form (including its medical/surgical authorization).

Current phone number: _____

Do you have any current infectious diseases? Yes No

List any physical limitations you may have: _____

Current Prescription Medications: Name of Medication Dosage Times Given

(Attached additional sheet for more medications) _____

INITIAL COUNSELORS NEED: 3 REFERRALS (see the Counselor Reference Check form) (Required by State of MI)

RETURNING COUNSELORS NEED: 3 REFERENCES THAT YOU GIVE US PERMISSION TO CONTACT (Required by State of MI)

Name	Relationship	Email Address	Mailing Address
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

***My signature indicates that everything on this form is accurate and true.**

Signature _____

If further information is needed, contact Doug Ammeraal at (616) 218-4633 or email campsunshinemi@gmail.com or visit our website at www.campsunshine.info.

If you have not received an email confirmation by mid May and/or written confirmation by May 30, please contact the Camp Sunshine office at 994-9897 or Doug Ammeraal dougammeraal@gmail.com

**Return To: Camp Sunshine
PMB 200
430 E. 8th Street
Holland, MI 49423**

This Form Must Be Completed and Signed!

Return this form ASAP in order to complete Camper/Counselor pairing.

The final day to return form is May 25, 2012

