

**Camp Nyoda**  
**136 Cozy Lake Road**  
**Oak Ridge, NJ 07438**  
**973-697-4382**

I authorize a licensed physician at the **CHILTON MEMORIAL HOSPITAL** and/or **MORRISTOWN MEMORIAL HOSPITAL** and/or **A SPECIALIST CONTRACTED TO TREAT THOSE IN ATTENDANCE AT CAMP NYODA** to evaluate my child,

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(Name)

in the event that she is taken ill or is in an accident. Should treatment be deemed necessary by said physician, and in the event that I cannot be reached after every reasonable effort has been made to do so, I also authorize such treatment in advance. In such an event, the Camp Director or her designee may sign the hospital authorization forms for treatment.

A copy of the form may be considered as valid in lieu of the original. I reserve the right to revoke this authorization at any time in writing and in the absence of said written revocation, this authorization shall continue in full force and effect.

Date of last tetanus: \_\_\_\_\_

Allergic reactions to tetanus: \_\_\_\_\_

Medically important information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Mother's Numbers: \_\_\_\_\_  
Home Work Cell

Father's Numbers: \_\_\_\_\_  
Home Work Cell

If neither parent can be reached call: \_\_\_\_\_  
Name Relationship

\_\_\_\_\_ Home Work Cell