MEDICAL AUTHORIZATION

THIS FORM MUST BE SIGNED BY PARENT/GUARDIAN OF THE FOLLOWING CAMPER:
(A separate form is required for *each camper*)

Camper Last Name: _____ Camper First Name: _____

If my child becomes exposed to any infectious disease between now and the time of departure for the camp, I understand the Camp must be notified.

In case of medical and/or a surgical emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment and to order injections, anesthesia, medication, X-rays, surgery or any other appropriate measure for the person as named above.

I understand that in such an emergency, it is the camps policy to make every effort to reach the parent/guardian in advance of treatment. I hereby give permission to the attending camp physician to contact my physician where deemed medically necessary. I hereby agree that the relationship and the resolution of any and all disputes arising therefrom between myself, and health services provided through Camp Ramah in Canada shall be governed by and construed in accordance with the laws of the Province of Ontario.

I hereby acknowledge that the treatment will be performed in the Province of Ontario and that the courts of the Province of Ontario shall have jurisdiction to entertain any complaint, demand, claim or cause of action whether based on alleged breach of contract or alleged negligence arising out of the treatment. I hereby irrevocably submit to the exclusive jurisdiction of the Courts of the Province of Ontario.

While Camp Ramah in Canada, the National Ramah Commission, and all provincial and state public health departments all strongly encourage full childhood immunizations, there are several immunizations which are ***mandatory*** *to update prior to camp. Please visit our website for Camp Ramah's Immunization Policy for 2014. Click here for our immunization policy. The establishment of a safe camp environment must therefore include the requirement that all members of the Camp Ramah community be adequately immunized according to the routine childhood schedule. This is a public health policy that Camp Ramah must endorse.*

Please print, sign and return this form by **May 9, 2019** to:
Camp Ramah in Canada 310-3845 Bathurst Street Toronto, ON M3H 3N2
I have read, understand and accept the conditions on this form.

Signature of parent/guardian of camper: _____

Print name of signatory: _____ Date: _____

If your child is not immunized, your camper application will be pending until further review. You will receive a call from the camp office.

If you have any questions or concerns, please contact Reena at 416-789-2193 ext. 2100
or info@campramah.com.

MUSKOKA ALGONQUIN HEALTHCARE
Proudly serving our communities through quality healthcare.

☐ CODED _____

ENC# Patient ID #
Patient Name
DOB AGE Gender
PROVINCIAL HEALTH NO.
Address:
Res. Code

Telephone: Workload:

GOVERNING LAW AND JURISDICTION AGREEMENT

GOVERNING LAW

I hereby agree that:

a) all aspects of the relationship between me and Muskoka Algonquin Healthcare (as well as its agents, delegates, employers, and any physicians and other independent health care practitioners providing medical or other health care and treatment to me at or in association with Muskoka Algonquin Healthcare), including without limitation any medical or other health care and treatment provided to me, and

b) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this Agreement, shall be governed by and constructed in accordance with the laws of the Province or Territory of Ontario and the laws of Canada applicable therein.

JURISDICTION

I hereby acknowledge that the medical or other health care and treatment I receive from Muskoka Algonquin Healthcare will be provided in the Province or Territory of Ontario, and that the Courts of the Province or Territory of Ontario shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising from or in connection with that medical or other health care and treatment, or from any other aspect of my relationship to Muskoka Algonquin Healthcare.

Date _____

_____ _____

Name of Patient (please print) Signature of Parent/
Substitute decision-maker on behalf of patient

Please provide your credit card details to cover the costs of any incidentals, x-rays, medications, procedures or medical services that may be required during your visit to Muskoka Algonquin Healthcare or any other health service provider necessary, such as dentist or orthodontist.

METHOD OF PAYMENT

Credit Card: ☐ MasterCard ☐ Visa

Credit Card Number: _____ Exp. Date _____ Verification Code _____

Name of Card Holder: _____

☐ Please check if you authorize Camp Ramah to use your credit card on file, in lieu of re-entering your credit card information above.