

Camper Name: _____ Birthdate: _____
First Middle Last Month/Day/Year

NOTARIZED STATEMENT OF RESPONSIBILITY

In lieu of supplying a Copy of a Health Insurance Card for the above named Camper, please accept this Notarized Statement of Responsibility for Medical Payments.

I am the Parent or Guardian of the above named Camper and I understand that in the event of a serious illness, accident or emergency, I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injections, anesthesia, or surgery for this child.

I understand that in the absence of health insurance for the above named Camper, I will be personally responsible for all medical costs.

By my signature below, I absolve Wekiva Youth Camp and the Florida Federation of Garden Clubs, Inc. of all responsibility and liability for any injuries, illnesses, claims, damages, charges, bills and/or expenses incurred while the above named Camper is at Wekiva Youth Camp, or that may be incurred after leaving Wekiva Youth Camp as a result of some injury, illness, incident or disease encountered.

THE FOLLOWING SECTION MUST BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC

Parent or Guardian Signature Date

TO BE COMPLETED BY NOTARY PUBLIC:

_____ (parent/guardian's name) personally appeared before me and swore or affirmed that she/he freely and without reservation signed this Notarized Statement of Responsibility.

Date Notary Public, State of Florida My commission expires

Affiant's identification has been validated by: _____