



# 2026 MEDICAL RELEASE, EMERGENCY CONTACT

To be completed by Parent or Guardian

PRINT CAMPER'S NAME \_\_\_\_\_  
First Last

DATE OF BIRTH \_\_\_\_\_ FALL GRADE \_\_\_\_\_  
MM DD YYYY

Please identify the following contacts who will be contacted by the OVS Summer Camp Health Center staff in the event that your Camper is in need of medical attention.

**PRIMARY CONTACT:** \_\_\_\_\_  
First Last Relationship  
CELL #: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, COUNTRY \_\_\_\_\_

**SECONDARY CONTACT:** \_\_\_\_\_  
First Last Relationship  
CELL #: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, COUNTRY \_\_\_\_\_

In the event that the Primary or Secondary contacts are unavailable:

**EMERGENCY CONTACT:** \_\_\_\_\_  
First Last Relationship  
CELL #: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, COUNTRY \_\_\_\_\_

### AUTHORIZATION TO CONSENT TO TREAT A MINOR

I, the undersigned, parent/guardian of the above camper, a minor, do hereby authorize designated OJAI VALLEY SCHOOL staff to act as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment (including first-aid delivered on Ojai Valley School's campuses and off-campus) and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the California Medicine Practice Act and/or Dental Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician, at a hospital, or other location deemed appropriate as well as supervised by designated Ojai Valley School staff.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment (including first-aid) or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 6910 of the Family Code of California and Section 1283 of the Health and Safety Code of California, and authorizes any hospital or physician's office that has provided treatment to the above-named minor to surrender physical custody of such minor to the above-named agent(s) upon completion of treatment. These authorizations shall remain effective until revoked in writing and delivered to said agent(s).

**PARENT'S AUTHORIZATION TO OJAI VALLEY SCHOOL:** You may administer such treatments and medications to my child as may be recommended by medical personnel deemed competent by school authorities. *Every effort will be made to contact parent/guardian if an illness, injury or emergency should arise.*

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_