

## Camp Willson Consent Form

**Camper Name:** \_\_\_\_\_ is permitted to attend the Kappa Kidney Camp organized by the National Kidney Foundation Serving Ohio held at the YMCA Camp Willson Outdoor Center in Bellefontaine, Ohio.

**I give consent for the National Kidney foundation Serving Ohio to provide the following:**

1. Transportation to and from camp for hemodialysis during the camp week, as well as to Off-site activities.
2. Medical staff consisting of nephrologists, nurses and dialysis technicians to administer medications, medical treatment, including but not limited to hemodialysis and peritoneal dialysis.
3. Lay staff, to supervise planned activities that will include, but are not limited to arts and crafts, swimming, boating, softball, horseback riding, hiking, basketball, tennis, bowling and fishing.

**I understand that:**

1. Camp is operated by YMCA Willson Outdoor Center and not by the National Kidney Foundation Serving Ohio.
2. Meals will be planned, prepared and provided by YMCA Willson Outdoor Center.
3. Sleeping accommodations will be in cabins maintained and operated by YMCA Willson Outdoor Center
4. Hemodialysis treatments will be provided to all hemodialysis campers at a dialysis facility.
5. Facilities to treat patients' Hepatitis B surface antigen positive or HIV positive are not available. Children with active chicken pox are not eligible to attend Camp.
6. It is the responsibility of the parent/legal guardian to provide transportation to and from Camp.

I give permission for the camper to take part in these activities unless otherwise noted in writing. I also acknowledge and understand the above stated conditions and circumstances.

I agree to hold harmless the YMCA, its' agents and employees for all claims alleging bodily injury or property damage occurring while the undersigned is a participant at a YMCA sponsored activity on or off the YMCA premises. I do not hold harmless the YMCA from any liability or injury arising out of negligence of the YMCA.

I hereby give permission to the medical personnel selected by the Camp Director to order X-rays, routine tests, treatment and necessary transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Names of anyone NOT permitted to see or pick up my child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Camper: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**Complete and return by June 24, 2009 to:**

**Mrs. Lisa Cassell  
2382 Shrewsbury Road  
Upper Arlington, OH 43221**