MEDICAL INFORMATION FORM

MEDICAL INSURANCE

Participant's Name _____ Age _____

Street Address _____City _____ State ____ ZIP _____

Parent/Guardian Name _____

Cell Phone _____ Home Phone _____ Work Phone _____

Parent/Guardian Name _____

Cell Phone _____ Home Phone _____ Work Phone _____

Another Neighbor or Relative

Name_____ Cell Phone _____

PRIMARY INSURANCE INFORMATION

Parent's Insurance Covering Participant _____

Insured Date of Birth _____ Policy Number/Member ID # _____

Insurance Company Phone _____

Insurance Company Address _____

Second Parent's Insurance (if participant is covered) _____

Insured Date of Birth _____ Policy Number/Member ID # _____

Insurance Company Phone _____

Insurance Company Address _____

☐ Check and sign below if participant does not have health care coverage.

Signature of Parent/Guardian _____ **Date** _____

You must submit a copy of the front and back of all insurance and prescription identification cards covering participants.

MEDICAL INFORMATION FORM

MEDICAL AUTHORIZATION

Participant's Name _____ Birthdate _____

Street Address _____City _____ State ____ ZIP _____

Phone _____ Emergency Phone _____

Physician's Name _____

Practice of Physician _____

Address _____City _____ State _____ ZIP _____

Phone _____

Medication Name _____ Purpose _____

Dosage Frequency _____

Instructions on how to give medicine _____
_____
_____

Any other pertinent information regarding child and medication _____
_____
_____

If your child has allergies, please list them here _____
_____
_____

EMERGENCY FORM FOR MEDICATION

Even if you do not have medicines that need to be administered during camp hours. Please sign below in case of emergency.

For ALL Parents/Guardians:

By signing below, I agree that I am primarily responsible for administering medications to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the _____ and its employees and agents, on my behalf, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employee and agents of the) _____) lawfully prescribed medication in the manner described above.

I agree to indemnify and hold harmless the _____ and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____ Date _____