

EMERGENCY & HEALTH INSURANCE FORM

EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE

Private insurance information must be provided, if applicable. If a participant does not have private health insurance, please be advised that, should a participant require medical attention, you are responsible for paying any costs not covered by insurance.

Participant's Name _____ AGE _____ Birthday _____

Participant's Address _____

City _____ State _____ Zip _____

Participant's Home Phone # _____ WEEK(s) Attending _____

INSURANCE INFORMATION:

Insurance Company _____ Effective Date _____

Insurance Company Address _____

Insurance Company Phone Number _____ Group # _____

Policyholder's Name _____ Policy # _____

Policy Holder's Address _____

Relationship to Participant _____

Contact Number _____ Employee Number _____

Name of Primary Care Physician _____

Physician Phone Number _____

Contact Person(s) In Case Of Emergency

Name _____ Relationship _____

Address _____

Day Phone _____ Evening Phone _____ Cell _____

Name _____ Relationship _____

Address _____

Day Phone _____ Evening Phone _____ Cell _____

I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.

I request that payment under my medical insurance program be(made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for fees not covered by this authorization.

Parent/Guardian Signature: _____ Date _____