MEDICAL INSURANCE INFORMATION - Submit a copy of the front and back of all insurance and Rx identification cards

Participant's Name: _____
Last First Middle Initial

Address: _____
Street Apt. #

_____
City State Zip

Participant's Social Security number: _____ Age: _____

Business Phone: Mother: _____ Father: _____

Home Phone: Mother: _____ Father: _____

Neighbor or Relative's Name: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Insured: _____ Date of Birth: _____

Policy Number: _____ Member ID #: _____

Insurance Co.: _____ Phone #: _____

CHECK AND SIGN IF PARTICIPANT HAS NO HEALTH COVERAGE

(if participant has coverage continue form below)

[ ] There is no health insurance coverage for this participant at this time.

Signature: _____ Date: _____

Excess Insurance: Insurance coverage is provided on an **excess** basis only. The participant's personal health insurance policy will be primary and provide coverage for accident and sickness. In the event the participant does not have health insurance this policy will provide coverage for accident and sickness. Pre-existing conditions are not covered.

Summary of Excess Benefits & Limitations

• Accident Medical Expense (Excess)	$25,000	• Deductible	Nil
• Accident Dental Expense (Excess)	Included	• AD&D and Paralysis, Principal Sum	Nil
• Sickness Medical Expense (Excess)	$500	• Benefit Period	One Year

PHOTO USE PERMISSION

I hereby grant the 4-H program, University of Kentucky and their agents, the right to use, reproduce, assign, and/or distribute still pictures, video, and sound recordings of myself or my minor child without compensation for use in promotion/advertising, educational publications or website content which they may create.

Signature: _____ Date: _____

Important – This box must be complete for attendance*

Parent/Guardian Authorizations: All information provided on the Insurance Form, Health History and Medication Form are correct and complete as far as I know. The person herein described has permission to engage in all event activities except as noted. I hereby give permission to the event designee to provide routine health care, administer prescribed and over the counter medications, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the event staff to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the event staff to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian/participants over 18 years: _____

Printed Name: Date:

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Disabilities accommodated with prior notification.