Participants Name _____

DUKE Fall ID Clinic HEALTH FORM

This form must be completed and signed by the participant's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session. **This form will be returned to you if it is incomplete**. Please type or print in **black ink.**

PARTICIPANT INFORMATION

Participants Name _____
Permanent Address _____Date of Birth _____ Sex ___
City/State/Zip _____Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first: Backup contact (relative or friend):
Name _____Name _____
Relation _____Relation _____
Daytime Phone _____Daytime Phone_____
Evening Phone_____Evening Phone_____

INSURANCE POLICY INFORMATION

The above-named child is covered by health insurance: Yes No
If yes, provide the following information which is required by Duke University Medical Center to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name_____P.H.'s Date of Birth _____
Address_____Relation_____
City/State/Zip _____Occupation _____
P.H.'s Employer_____
Employer's Address_____
Insurance Company_____
Insurance Company's Address_____
Policy # _____Plan # _____

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named camper, authorize the Duke Summer Program staff to seek medical treatment for the camper as they see necessary at Duke University Medical Center or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Program staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon a possible of any and all diagnoses and treatments.

_____ _____ _____

Legal Guardian's Signature Print Name Date