SPORTS CAMPS

MEDICAL INSURANCE FORM

Camper Information

Name _____ Camper _____
Birthdate _____ Home Telephone No. _____
Home Address _____ Cell Telephone No. _____
_____

Parent/Guardian Information

Father's Name _____ Mother's Name _____
Address _____ Address _____
_____ _____
Daytime Telephone _____ Daytime Telephone _____
Employer _____ Employer _____

Medical Insurance Information

EFFECTIVE DATE: _____
Insurance Co. Name _____ Subscriber's Name _____
Claims Address _____ Subscriber's Birth Date _____
_____ Subscriber's Social Security _____
City _____ ID/Agreement No. _____
State _____ Plan/Group/Policy No. _____
Zip Code _____ Telephone No. _____

HMO/Primary Care Physician, Address and Telephone No.

_____
_____

I hereby authorize the release my medical insurance information necessary to process an insurance claim for the medical care of my daughter/son and that the payment of medical benefits, by my insurance company, be made directly to the physician/provider of medical services rendered.

Signature: _____ **Date:** _____