

Please list any medications being taken and include dose & frequency.

III. INSURANCE INFORMATION (Participant **MUST** be covered by a health insurance policy.)



Primary Insurance

Secondary Insurance

Company Name: _____

Company Name: _____

Company Address: _____

Company Address: _____

Ins. Company phone: _____

Ins. Company phone: _____

Med. Ins. Policy Number: _____

Med. Ins. Policy Number: _____

Med. Ins. Group #: _____

Med. Ins. Group #: _____

Name of person insured: _____

Name of person insured: _____

DOB of insured: _____

DOB of insured: _____

SS# of insured: _____

SS# of insured: _____

Employer of insured: _____

Employer of insured: _____

IV. MEDICAL TREATMENT AUTHORIZATION & LIABILITY RELEASE

I, the undersigned parent or guardian, do hereby grant my permission for my son/daughter to attend the Miami University summer activity and fully participate in all activities thereof. In the event of an injury or illness during these activities, even if I cannot be directly contacted at the time, I hereby authorize Miami University and/or McCullough-Hyde Hospital to provide the medical treatment they deem necessary. I hereby release Miami University, the treating physician and the treating hospital and their agents, employees, and representatives from any and all claims and liability arising in any way out of its exercise of this authority. I understand and agree that all bills for medical care and treatment will be forwarded to me or my insurance company, and that it will be my responsibility to see that such bills are paid. I further acknowledge, understand, and agree that in participating in this activity, program, or workshop there is a possibility of physical illness and/or serious injury. My son/daughter and I hereby assume all risk of such illness and injury. I further authorize the program staff to administer non-prescription analgesics for minor medical problems such as headaches, etc.

Parent/Guardian Signature

relationship

Date