Insurance Information

Participant's Name **Birth Date** **Social Security #**

You MUST submit a copy of the front and back of all health insurance cards covering participant "With Registration".

☐ Check box and sign below if participant has NO health insurance coverage.

Date Signature (Parent/Guardian if claimant is a minor, under 18)

Consent to Medical Treatment/ Insurance Statement: It is understood that authority is given to the MSU activity director or their designee, to have my son/daughter treated for injuries or illness they incur during an MSU camp, conference, or field trip activity.

In the event I cannot be contacted, I hereby give my permission for the MSU activity director or their designee to seek advanced medical treatment for my son/daughter as deemed necessary by competent medical personnel.

I understand that the MSU insurance coverage is on an "excess" basis only and I will be responsible for any expenses outside of the limits of MSU's insurance.

Authorization to Release Information: I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding my medical treatment or benefits payable, including disability to any Allen Flood Company, the Plan Administrator or authorized personnel for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a Photostat copy of the original shall be valid for the duration of the claim.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits for services rendered and billed as a result of this claim to be made payable to the physicians and providers indicated on the invoices.

Date Signature (Parent/Guardian if claimant is a minor, under 18)

Emergency Contact Information

Name:_____Relationship:_____Phone number: _____Additional number: _____during activity dates

Medical Screen Form: (to be completed by a physician) **OR** provide a copy of a physical exam form signed by a physician indicating clearance to participate. This form must be dated within 12 months of the date of the camp.

Head	Yes	No	
ENT	Yes	No	
Neck, Back	Yes	No	
Heart	Yes	No	
Abdomen	Yes	No	
Genitalia	Yes	No	
Extremities	Yes	No	

Asthma	Yes	No	(circle one)
Currently taking ANY			
prescription medication	Yes	No	(circle one)
Please list:			
Date of last tetanus shot or booster:			
Known allergies:			

Comments:_____

Sports Participation Approved: Yes No Limitations: Yes No

Physician's signature: _____Date:_____ _____

Physician's Phone Number: _____

Disabilities accommodated with advanced (4-6 weeks) notification