UF/IFAS Summer Camp
CONTACT/MEDICAL INFORMATION

Student: _____

Social Security #: _____ Birthdate: _____

Parent(s)/Guardian(s) Names: _____/_____

Home Address:_____

City:_____ State:_____Zip Code: _____

Home Telephone: (____)_____ Cell Phone: (____)_____

Parent(s)/Guardian(s) Work Telephone(s) (____)_____ (____)_____

Another Person to Contact in Case of Emergency: _____

Phone Number: (____)_____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Insured's Name: _____

Insured's Social Security Number:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone:_____

Policy Number: _____ Fax Number: _____

Plan Type or Code Number: _____

MEDICAL INFORMATION

The following section is to include special allergies or medical conditions that might require special attention during the UF Entomology Field Camp (PROGRAM). Examples are food, drug or insect allergies, diabetes, chronic illness, recent surgery, fainting spells, etc. It must also include any hospitalizations for any reason, any regularly prescribed medications, and any special or psychological examinations, conditions, or treatments.

Allergies _____

Chronic Conditions (Asthma, etc.) _____

Regular Medications _____

Medical History _____

_____

Parent(s)/Guardian(s) Signature(s) Date

MEDICAL AUTHORIZATION

PARENTAL CONSENT & AUTHORIZATION

We/I understand that our/my son/daughter _____ who is _____ years old and an academic-year student at _____ has been selected to attend the UF Entomology Field Camp (hereinafter "PROGRAM") to be held on the campus of the University of Florida.

We/I understand that my/our health insurance, if available, will be the primary coverage for _____ (Child's name) in the event of accident or illness while attending the PROGRAM. We/I further understand that in the event we/I do not have insurance or have exceeded our coverage limits, our/my son/daughter will be insured by the sponsors/administrators of the PROGRAM for accident and illness occurring during the participant's attendance in the PROGRAM and excluding pre-existing medical conditions. The policy will be arranged through University of Florida and will be in effect for the duration of the PROGRAM. Upon written request, a copy of the policy will be sent to parents or guardians when it is available. This coverage will be effective from 8:00 am until 5:00pm Monday-Friday of the camp, exclusive of time away from the PROGRAM as approved by the Director or the Director's Designee.

We/I also authorize the sponsors/administrators of the PROGRAM and authorized representatives of the Insuring Agency to obtain information regarding the medical history, physical condition, and diagnosis of our/my son/daughter as required to document covered accidents/illnesses. A photocopy of this authorization shall be valid as the original. This authorization will be valid for the term of our/my son/daughter's coverage under the policy.

We/I, the parent(s) or guardian(s) of _____, do hereby request that the University of Florida, through its agents or employees, take whatever steps necessary to secure medical treatment for the child named above in the event such child appears to be in need of such treatment while attending the PROGRAM. We/I consent to the rendering of all necessary treatment including admission to a hospital or other appropriate health care facility, in such institutions and at such places as the University, acting through its agents or employees, deems best. I authorize the agents or employees of the University to execute whatever forms might be necessary to ensure complete and adequate care of our/my child.

We/I affirm that the above medical information is complete and accurate. We understand that pre-existing health conditions are not covered by the University or the PROGRAM insurance and that such conditions are the financial responsibility of the parent(s) or guardian(s). We/I also understand that the insurance policy cited above does not cover any medical problems known to us/me or that should have been known to us/me and not revealed by us/me to the University or the PROGRAM, and that certain conditions will not be covered under the terms of the insurance policy.

If this document is being signed by only one parent, I, the undersigned, affirm that I have been judicially granted sole custody of the participant. If this document is being signed by a guardian(s), I/we, the undersigned, affirm that I/we have been judicially granted legal guardianship of the participant.

_____ _____

Student Participant Signature Date Parent or Guardian Signature Date

_____ _____

Student Participant Signature Date Parent or Guardian Signature Date