Participant's Name _____

AIM-HIGHER 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

Participant's Name _____
Permanent Address _____ Date of Birth _____ Sex ___
City/State/Zip _____ Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:
Name _____
Relation _____
Daytime Phone _____
Evening Phone _____

Backup contact (relative or friend):
Name _____
Relation _____
Daytime 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 Nova Southeastern 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 Nova Southeastern University Program staff to seek medical treatment for the camper as they see necessary at Nova Southeastern 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 the above-named person or me before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon as possible of any and all diagnoses and treatments.

Legal Guardian's Signature _____ Print Name _____ Date _____