


Participant's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

University of Kentucky activities are covered by Allen Flood Insurance. This insurance plan is *secondary* to the participant's own primary plan. For detailed information regarding the policy coverage benefits and limits please visit the U.K. Risk Management website at <http://www.uky.edu/EVPFA/Controller/riskhome/excess.html> or call 859/257-3708.

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

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

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

 Disabilities accommodated with advanced (4-6 weeks) notification.

**Consent to Medical Treatment/Insurance Statement**

It is understood that authority is given to the U.K. activity director or their designee, to have my son/daughter treated for injuries or illnesses they incur during a U.K. camp, conference, or field trip activity.

In the event I cannot be contacted, I hereby give my permission for the U.K. 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 U.K. insurance coverage is on an "excess" basis only and I will be responsible for any expenses outside of the limits of U.K.'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 or Guardian if claimant is a minor, under 18)

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(please print)

Phone number **during activity dates:**(\_\_\_\_\_) \_\_\_\_\_ Additional number:(\_\_\_\_\_) \_\_\_\_\_

**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 Physician's Signature: \_\_\_\_\_  
Limitations: YES NO Physician's Phone Number: ( ) \_\_\_\_\_  
Date: \_\_\_\_\_

DATE:

CAMP:

FIRST NAME:

LAST NAME: