Eastern Illinois University
School of Extended Learning
600 Lincoln Avenue
Charleston, IL 61920
(217) 581-5114

MEDICAL TREATMENT AND BILLING AUTHORIZATION

This form is for use in case of an emergency and for overnight care. This information will be used by the staff members and by appropriate Health Care personnel and will not be released to anyone else without your knowledge or consent.

PLEASE PRINT LEGIBLY.

Program: Creativity Camp (5th – 8th Grade) (Summer 2023)

Arrival Date: June 26, 2023 Departure Date: June 29, 2023

Student's Last Name	First	Middle		
Home Address	City/Town	ZIP		Home Phone
Date of Birth	Place of Birth	Age	Gender	Religious Preference (optional)
Hospital/Health Insurance Co.	Insurance Company Phone Number			Policy Number
Address of Insurance Co.				
Name of Policy Holder		Policy Holder's Number		
Employer of Policy Holder		Employer's Address		

HMO Information (if applicable): _____

Pre-Treatment Authorization Plan Number (if applicable): _____

Father's Name	Home Phone	Work Phone
Mother's Name	Home Phone	Work Phone
Name of Person to Contact in Case of Emergency		Relationship to Student
Address	City/Town	Phone Number
Alternate Contact		Relationship to Student
Address	City/Town	Phone Number

Please complete both sides of this document. Thank you.

MEDICAL INFORMATION

(Please check all of the following which apply now)

- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart or Lung Condition
- ❑ Physical Handicap
- ❑ Allergies (Please list medication)

  _____

  _____
- ❑ Emotional/Depression, Please Specify_____
- ❑ Illness Currently Under Treatment With Medication
- ❑ Contagious Disease or Recent Exposure
- ❑ Orthopedic conditions, injuries, or surgeries within past year, please explain:_____

Date of most recent tetanus booster (Month/Day/Year): _____

Significant Health Concerns (i.e. allergies, disabilities, chronic conditions): _____

Does the student have any conditions which might limit physical activities? If so, please state: _____

I hereby authorize any medical treatment for my son/daughter which may be advised or recommended by the medical personnel in area hospitals. I furthermore agree to be responsible for financial charges incurred as a result of infirmary care, ancillary services (x-rays, for example), and other services not covered by my/our health and hospitalization plan.

Signature Required

Signature of Parent/Guardian Date

HEALTH AND INSURANCE: Each applicant must have a **Medical Treatment and Billing Authorization Form** signed by a parent/guardian, stating camper is in good health and who to contact in case of an emergency.

Eastern Illinois University requires that all campers carry health insurance coverage. The parent/guardian's personal or injury insurance policy will be utilized as the primary insurance policy for the treatment of injuries and hospitalization for illness or injuries incurred during the camp. The name of health insurance carrier (and policy number) must be written on the **Medical Treatment and Billing Authorization Form** in order to attend. If you do not possess health coverage, a temporary policy must be purchased (through your insurance agent) to cover the camper for the duration of the camp.

PLEASE ATTACH A PHOTOCOPY OF THE CAMPER'S HEALTH INSURANCE COVERAGE IDENTIFICATION CARD TO THIS FORM.

Signature Required

I hereby agree to the above terms.

Signature of Parent/Guardian Date

Please complete both sides of this document. Thank you.