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: Invention Squad: Building Towards the Future Using LEGO® Bricks (Summer 2023)

Arrival Date: August 3, 2023 Departure Date: August 5, 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.