2016 Hack Camp Health Form

This form must be completed and signed by the participant's parent or legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while the program is in session.

PARTICIPANT INFORMATION

Participant's Name_____ DOB_____

Permanent Address_____

City/State/Zip_____ Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Primary contact first: Secondary contact (relative or friend):

Name_____ Name_____

Relation_____ Relation_____

Daytime Phone_____ Daytime Phone_____

Evening 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 Hack Club 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 participant, authorize the Hack Club staff to seek medical treatment for my child as they see necessary at a 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 Hack Club 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 participant. 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 Hack Club program staff will make a good faith effort to contact me, or the above-named person(s), before seeking treatment. If this is not possible, I understand that the Hack Club 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

_____

Directions: Completion of this form by a parent or guardian is required before a student can participate. Please answer all questions. Please type or print in black ink. Attach any specific recommendations from your physician to this form.

_____

DOES THE PARTICIPANT CURRENTLY HAVE ANY OF THE FOLLOWING?

(if yes, please describe)

Drug allergies:_____

Food allergies:_____

Special dietary needs:_____

Asthma:_____

Frequent headaches: _____

Dizziness or seizures: _____

LIST: Other health problems:

_____

_____

Limitations of Activities:

_____

_____

Medications the participant is currently taking:

_____

_____

_____

(**Please note:** Our staff cannot administer any medications, prescription or non-prescription to participants. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the participant will need to take medications while attending our program, he must bring the medication to Hack Camp and assume responsibility for taking it as needed or indicated.)

Will your daughter or son require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain.

Yes No

_____

_____

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