Emergency Participant Information (Mandatory for all participants)

All information provided below is kept confidential and only shared if medically deemed necessary.

PART 1: PERSONAL DATA (Please Print Clearly)

PARTICIPANT NAME_____
Last Name First Name Middle Initial

HOME ADDRESS_____
Street & Number City/Town State Zip Code

INSURANCE (Medicaid/Etc)_____Policy # _____Group # _____

PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD.

IF YOU ARE CURRENTLY UNDER A DOCTORS CARE PLEASE PROVIDE HIS/HER NAME AND PHONE NUMBER

PHYSICIAN'S NAME_____ PHONE NUMBER_____

CONDITION YOU ARE BEING TREATED FOR_____

CURRENT
MEDICATION_____

MEDICAL
HISTORY_____

ALLERGIES (Ex. food, medication, insect stings)_____

PART 2: PARENT/GUARDIAN CONTACT INFORMATION (Enter in sequence to be contacted) Please Print Clearly

NAME_____PHONE #_____CELL #_____

RELATION_____ADDRESS_____ZIP_____

EMPLOYER_____WORK PHONE_____

NAME_____PHONE #_____CELL #_____

RELATION_____ADDRESS_____ZIP_____

EMPLOYER_____WORK PHONE_____

IF THE ABOVE CANNOT BE REACHED CONTACT _____RELATIONSHIP_____

PHONE #_____WORK PHONE #_____CELL #_____

PART 3: CONSENT TO BE TREATED AND MEDICAL INFORMATION TO BE RELEASED

In the event of a serious accident or illness, I hereby authorize the above named physician (If listed) or his staff to release and provide protected health information on the above named participant.

In the event of an EMERGENCY in order to expedite care I give permission for **Academic and Performance Travel LLC** in addition to the participating school, teachers, chaperones and their agents including all theme parks and facilities to provide medical information to the responding emergency team to initiate treatment, and transport to an appropriate facility. I also give my permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival to the appropriate facility. I request to be notified of my child's condition and admission as soon as possible. If I cannot be reached, I request that the admitting facility notify one of the other persons listed above of my child's condition and admission. I agree to be financially responsible for my child's total treatment, and transport.

Partent/GuardianSignature_____Date_____

THIS FORM IS EFFECTIVE FOR ONE YEAR FROM THE DATE SIGNED