Medical Insurance Usage and Health Information
You ***MUST*** *sign the bottom of this section.*

If you are providing Insurance information you MUST include a photo copy of your insurance card.

Participant's Full Name:_______________________________________

Parent(s)/Guardian(s) Name(s):__________________________________
____

Address:____
(street) (city) (zip)

Phone:____________________ Alt Phone:________________________

Name of Insured:____

Relationship to Youth:____

Youth SSN:_____-____-______Insured's SSN:_____-____-______
(Omitting SSN #'s may result in a delay of medical care)

Insurance Carrier:____

Group Number/ID and Policy Number:____________________________

Authorization Phone:____

Prescription Card Information:___________________________________

Please list any necessary medical/health information (ex: drug allergies):

____

____

Please list all medication your youth takes regularly:

____

____

Date of last Tetanus shot/booster: _____/______/______

Please list any other information about your young person that would be helpful for us to know:____

____

I,____________________________________, parent or guardian of:

________________________________authorize, by signing below, the use of this information in case of a medical emergency involving my youth by The Diocese of East Carolina employees, volunteers, and agents. I agree to be financially responsible for all costs incurred, regardless of whether medical insurance coverage information is provided.

____
(Signature of parent/guardian) (date)