

Camp session attending _____

**TRANSYLVANIA COMMUNITY HOSPITAL
BREVARD, NC 28712**

INFORMATION REQUIRED FOR MEDICAL TREATMENT

- *Please staple a copy of your insurance card to the back of this form*

STAFF INFORMATION

Name _____ Date of Birth _____

Address _____

Phone _____ Social Security _____

PARENT INFORMATION

Mother's Name _____ Social Security _____

Employer _____ Work Phone () _____

Employer's Address _____

Father's Name _____ Social Security _____

Employer _____ Work Phone () _____

Employer's Address _____

INSURANCE INFORMATION

Insurance Company Name _____

Address to mail claim _____

Phone # for benefits () _____ Group Name _____

Certificate or Policy # _____ Group # _____

Policyholder Name _____ Relationship to patient _____

EMERGENCY AUTHORIZATION

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for my child. In an emergency when I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

SIGNATURE OF PARENT/GUARDIAN/STAFF _____

WITNESS _____ **DATE** _____