

2012 Camp High Rocks Session Attending:

3wk     4wk     Mini I     Mini II     Starter I     Starter II     2wk

TRANSYLVANIA COMMUNITY HOSPITAL  
BREVARD, NC 28712

**INFORMATION REQUIRED FOR MEDICAL TREATMENT**

**CAMPER/STAFF INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Social Security \_\_\_\_\_

**PARENT INFORMATION**

Mother's Name \_\_\_\_\_ Social Security \_\_\_\_\_

Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Employer's Address \_\_\_\_\_

Father's Name \_\_\_\_\_ Social Security \_\_\_\_\_

Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

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 \_\_\_\_\_

Pre-Certification required? Y / N

**■ Please attach a copy of your insurance card with this form**

**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** \_\_\_\_\_ **DATE** \_\_\_\_\_