



BILLING AUTHORIZATION FOR MEDICAL TREATMENT

CAMP OR CONFERENCE ATTENDING _____

ARRIVAL DATE _____ DEPARTURE DATE _____

NAME _____
 LAST FIRST

ADDRESS _____
 STREET CITY STATE ZIP CODE

MALE/FEMALE _____ DATE OF BIRTH _____ AGE _____
 TELEPHONE # () _____

RESPONSIBLE BILLING PARTY

NAME OF PERSON RESPONSIBLE FOR BILLING _____

STREET ADDRESS _____ CITY STATE ZIP CODE

DAYTIME TELEPHONE # () _____ EVENING TELEPHONE # () _____

____ Please check if your insurance coverage is provided by Medicare or Medicaid (medical card) and attach a current copy of your card.

EIU HEALTH SERVICE IS NOT A PARTICIPATING PROVIDER IN THE ILLINOIS DEPT. OF PUBLIC AID PROGRAMS, INCLUDING THE KID CARE PROGRAM.

EIU Health Service charges for medical services are not covered by camp or conference fees unless otherwise specified in the camp or conference registration materials.

MEDICAL INFORMATION

(PLEASE CHECK ANY OF THE FOLLOWING WHICH APPLY NOW)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous or Emotional |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Illness Currently Being Treated |
| <input type="checkbox"/> Heart or Lung Condition | <input type="checkbox"/> With Medicine |
| <input type="checkbox"/> Physical Handicap | Other, please list _____ |
| <input type="checkbox"/> Contagious Disease or Recent Exposure | Date of Last Tetanus Shot _____ |
| <input type="checkbox"/> Orthopedic Conditions, Injuries, Surgeries | List any medications currently being taken _____ |
| <input type="checkbox"/> Within the Past Year, Explain _____ | |

ALLERGIES

- Do you have any drug allergies: YES/NO List drug allergies _____
- Any environmental allergies? YES/NO List other allergies _____
- List any medication taken for allergies _____

Please describe briefly any of the above medical information that has been checked: _____

TREATMENT & EMERGENCY CARE

Please Contact: _____ Relationship _____
 Address _____ Telephone # _____

UNDER 18 YEARS OF AGE

I do hereby authorize EIU Health Service to provide medical treatment and authorize transfer by ambulance if warranted for the above named person in the event this should become necessary while attending camp/conference at Eastern Illinois University. I also, hereby authorize consent for Health Service to share visit and treatment information with camp staff and allow camp staff to follow procedures for after care outlined by providers for the above named person.

Parent/Guardian Signature(s) _____ Date _____

***Registration to attend camp is not complete until this form is filled out, returned, and is on file at the Univ. Health Service.**
White—Health Service Yellow—Camp/Conference Guest Rev. 1-03