DAWN STALEY BASKETBALL ACADEMY HEALTH FORM

This form must be received prior to the start of camp. All completed forms should be mailed to: Dawn Staley Basketball Academy, 1051 Blossom Street, Columbia, SC 29208.

Participants Name:______________________________Birth Date:______________________________

Participants Social Security Number: ____

Dawn Staley Basketball Academy activities are covered by Pullen Insurance. This insurance is <u>*secondary*</u> *to the participant's primary plan.*

You must SUBMIT a copy of the front and back of all health insurance cards covering the participant.

☐ Check box and sign below if participant has NO health insurance coverage

Date:_______________ Parent/Guardian Signature:____________________________________

CONSENT TO MEDICAL TREATMENT/INSURANCE STATEMENT

It is understood that authority is given to the Dawn Staley Basketball Academy or its designee, to have my son/daughter treated for injuries or illnesses they incur while a participant at the Dawn Staley Basketball Academy.

In the event I cannot be contacted, I hereby give my permission for the Dawn Staley Basketball Academy or its designee to seek advanced medical treatment for my son/daughter as deemed necessary by competent medical personnel.

I understand that the Dawn Staley Basketball Academy insurance coverage is on an "excess" basis only and I will be responsible for any expenses outside of the limits of Dawn Staley Basketball Academy insurance.

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical treatment or benefits payable, including disability to any Pullen company, the Plan Administrator or authorized personnel for the purpose of validating and determining benefits payable.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits for services rendered and billed as a result of this claim to be made payable to the physicians and providers indicated on the invoice.

Date:_______________ Parent/Guardian Signature:____________________________________

Emergency Contact Name:____

Phone number **during camp dates**:____

MEDICAL SCREEN FORM

Medical screen form (to be completed by a Physician) or provide a copy of a physical exam form signed by a physician and dated within 12 months of the date of the start of camp.

Physician's Name:______________________________Physician's Phone:_______________________

Physician's Signature: ___________________________Date: __________________________________