

4. MEDICAL CONDITION

Do you have a chronic (long-lasting or persistent) medical condition or injury that requires treatment, monitoring or medication? [] Yes [] No

If **yes**, please have your physician send a summary of your treatment that includes the following:

- Condition being treated
- Type of medication
- Physician's address and phone number

5. AUTHORIZATION TO TREAT *If you are **over** 18 years of age*

I hereby authorize the physicians and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures, which in their judgment may become necessary while I am at BDI program. Medication(s) to which I am allergic or medication(s) that I am currently taking are listed on page 1 of this form. I agree that I will bring medication(s) I am currently taking with me to BDI camp or workshop and will consume the prescribed dosage for such medication(s). BDI will not administer or supply to me medication at its camp and or workshops.

Signature _____ **Date** _____

AUTHORIZATION TO TREAT *If you are **under** 18 years of age*

I hereby authorize the physicians and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures on the above named student, which in their judgment may become necessary while she/he attends BDI program. I waive all claims to prior notification. I understand that every effort will be made to notify me in the event of a major illness or injury, or if the physician feels it is necessary. Medication(s) to which my child is allergic or medication(s) that she/he is currently taking are listed on page 1 of this form. I agree that she/he will bring medication(s) she/he is currently taking with her/him to BDI camp or workshop and will consume the prescribed dosage for such medication(s). BDI will not administer or supply to her/him medication at its camp and or workshops.

Signature of parent/legal guardian _____ **Date** _____

6. PERSON (S) TO CONTACT IN THE EVENT OF AN EMERGENCY

Name _____ Relationship _____

Address _____

Daytime Phone (____) _____ Nighttime Phone (____) _____

E-mail Address (if any) _____

Name _____ Relationship _____

Address _____

Daytime Phone (____) _____ Nighttime Phone (____) _____

E-mail Address (if any) _____

7. MEDICAL INSURANCE INFORMATION Before travel abroad, know what medical services your health insurance will cover overseas. If your health insurance policy provides coverage outside the United States, **REMEMBER** to carry both your insurance policy identity card as proof of such insurance and a claim form. Although many health insurance companies will pay "customary and reasonable" hospital costs abroad, very few will pay for your medical evacuation back to the United States. Medical evacuation can easily cost \$10,000 and up, depending on your location and medical condition.

Insurance Company Name and Address _____

Policy No. _____ Group No. _____ Identification No. _____