Army Summer Sports Camps Camp(s) Attending
Army Athletics Summer Camps Form Sport: _____ Sess. Date:_____
Hold Harmless Sport: _____ Sess. Date:_____

General Information:

Camper Name:_____SSN:_____ (If DoD Dependent)
Date of Birth:_____ Age (when attending camp): _____ Sex: M/ F
Parent/Guardian Name:_____
Address:_____
Home Phone:_____ Cell:_____ Work:_____
Allergies:_____ Last Tetanus Shot (mo/yr):_____
Physicians Name:_____ Physicians Phone Number:_____
If parent/ guardian is not available in an emergency, notify:
Name:_____ Relation:_____
Phone:_____
Date **Parent/Legal Guardian Signature**

Insurance Information:

Camper Health Insurance Company Name and Policy:

Insurance Company:_____

Policy #:_____

I, authorize the agents of the above listed camp(s) to request emergency medical treatment for my dependent camper. Initials_____
I understand that emergency medical treatment may be provided at Keller Army Community Hospital at West Point. I understand that if I am not a military service member, emergency care will be provided on a temporary basis and that my child will be transferred to a civilian treatment facility if app
ropriate. Initials_____
I understand that Keller Army Community Hospital will file a claim with the insurance carrier providing accident coverage to the West Point Sports Camp. If I should receive payment for such claim, I will immediately forward the entire sum to Keller Army community Hospital, Attention: Business Office, West Point, NY 10996. Initials _____
I understand that any amounts remaining unpaid after settlement of a claim are my responsibility. I agree to remit the unpaid balance immediately to the Hospital Business Office. Initials _____
I understand that I am fully responsible for payment of charges related to medical treatment provided to my dependent camper that is required for any reason other than accidental injury. Initials _____
I hereby authorize the release of medical information for the purpose of determining third party and for obtaining additional medical care as required to safeguard the health of my child. Initials_____

Date **Parent/Legal Guardian Signature**