



## EVIDENCE OF HEALTH INSURANCE

I, the undersigned, hereby warrant and guarantee that my son/daughter is covered by the health insurance described below and that I have signed this authorization authorizing an adult member or chaperone of the group as my (our) agent for purposes of authorizing any x-ray, examination, anesthetic, dental care, medical or surgical diagnosis or treatment and/or hospital care as may be required, in the opinion of such agent.

It is understood that in the event that my son/daughter require any x-ray, examination, anesthetic, dental care, medical or surgical diagnosis or treatment and/or hospital care, which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician, dentist and/or surgeon, whether such diagnosis or treatment is rendered at the office of such physician, dentist and/or surgeon, in a hospital care and that the insurance coverage described below shall constitute the primary insurance coverage for the cost of all such diagnosis, treatment, and/or hospital care.

I, the undersigned, understand and acknowledge that neither the Academy by the Sea nor Camp Pacific, nor the College of Piping California Summer School of Piping shall under any circumstances be responsible for the cost of any such diagnosis, treatment and/or hospital care.

### INSURANCE INFORMATION

COMPANY: \_\_\_\_\_

POLICY #: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

INDIVIDUAL #: \_\_\_\_\_

NAME OF INSURED'S EMPLOYER: \_\_\_\_\_

DATE: \_\_\_\_\_

\_\_\_\_\_  
PARENT'S SIGNATURE

\_\_\_\_\_  
(Print name of person signing)

MEDICATIONS: \_\_\_\_\_

KNOWN ALLERGIES: \_\_\_\_\_

EMERGENCY PHONE NUMBERS: \_\_\_\_\_