

MEDICAL INFORMATION FORM

PLEASE FULLY COMPLETE THE FOLLOWING INFORMATION IN ORDER FOR YOUR CHILD TO PARTICIPATE IN ANY ORV ACTIVITIES AT KIDS IN THE MUDD FOUNDATION, INC.

Full Name of Child: _____ **Birth Date:** _____

Address: _____

Home Phone #: _____ **Cell Phone #:** _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Phone #:** _____

Name: _____ **Phone #:** _____

INSURANCE INFORMATION:

Health Insurance Company Name: _____

Policy # and I.D. #: _____

Address of Carrier: _____

KNOWN ALLERGIES OR CONDITIONS WE SHOULD BE AWARE OF:

I AFFIRM UNDER THE PAINS AND PENALTIES OF PERJURY THAT THE FOREGOING REPRESENTATIONS ARE TRUE AND CORRECT.

(PRINTED NAME)

(SIGNATURE)

Dated: _____

You must attach a copy of the front and back of your insurance card to this form

Received by: _____ **of Kids In The Mudd Foundation, Inc. On:** _____

