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: _____