



# REGISTRATION

## UK MEDICAL FORM

Participant's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

University of Kentucky activities are covered by a plan administered by the Allen Flood Company. This insurance plan is secondary to the participant's own primary plan. For detailed information regarding the policy coverage benefits and limits please visit the U.K. Risk Management website at <http://www.uky.edu/EVPFA/Controller/riskhome/excess.html>

**You MUST submit a copy of the front and back of all health insurance cards covering participant "With Registration".**

Check box and sign below if participant has NO health insurance coverage.

Date \_\_\_\_\_ Signature (Parent/Guardian if claimant is a minor, under 18) \_\_\_\_\_

## CONSENT TO MEDICAL TREATMENT/ INSURANCE STATEMENT

It is understood that authority is given to the U.K. activity director or their designee, to have my son/daughter treated for injuries or illness they incur during a U.K. camp, conference, or field trip activity.

In the event I cannot be contacted, I hereby give my permission for the U.K. activity director or their designee to seek advanced medical treatment for my son/daughter as deemed necessary by competent medical personnel.

I understand that the U.K. insurance coverage is on an "excess" basis only and I will be responsible for any expenses outside of the limits of U.K.'s insurance.

### Authorization to Release Information

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding my medical treatment or benefits payable, including disability to any Allen Flood company, the Plan administrator or authorized personnel for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a Photostat copy of the original shall be valid for the duration of the claim.

**PAYMENT AUTHORIZATION:** I authorize all current and future medical benefits for services rendered and billed as a result of this claim to be made payable to the physicians and providers indicated on the invoices.

Date \_\_\_\_\_ Signature (Parent or Guardian if claimant is a minor, under 18) \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number: \_\_\_\_\_ Additional number: \_\_\_\_\_  
during activity dates

## MEDICAL SCREEN FORM

**Medical Screen Form** (to be completed by a Physician) OR provide a copy of a physical exam form signed by a physician indicating clearance to participate. This form must be dated within 12 months of the date of the camp.

Head	Yes	No	
ENT	Yes	No	
Neck, Back	Yes	No	
Heart	Yes	No	
Abdomen	Yes	No	
Genitalia	Yes	No	
Extremities	Yes	No	

Asthma	Yes	No	(circle one)
Currently taking ANY prescription medication	Yes	No	(circle one)
please list:			
Date of Last Tetanus Shot or Booster			
Known Allergies			

Comments \_\_\_\_\_

Sports Participation Approved: Yes No Limitations: Yes No

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

Fill out, detach, and mail with check for total amount or \$50 deposit to:

**2009 Wildcat Baseball School**  
**Accounting Office, Joe Craft Center, 338 Lexington Avenue**  
**Lexington, KY 40506-0604**

Please indicate which camp you will attend by marking the corresponding box:

<b>JUNE 29th – 30th</b> <b>OWENSBORO, KY</b> Location: Jack C. Fisher Park <input type="radio"/> \$150	<b>JULY 10th – 11th</b> <b>PADUCAH, KY</b> Location: Brooks Stadium <input type="radio"/> \$150
<b>JULY 2nd – 3rd</b> <b>SOMERSET, KY</b> Location: Ward Correll Sports Complex <input type="radio"/> \$150	<b>JULY 24th – 25th</b> <b>ALEXANDRIA, KY</b> Location: Campbell County Penderly Park <input type="radio"/> \$150

Subtotal \_\_\_\_\_

Less Multi-camp/Sibling Discount(s) \_\_\_\_\_

**Total:** \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Grade Entering in Fall 2009 \_\_\_\_\_ Date of Birth \_\_\_\_\_

Primary Position \_\_\_\_\_ Secondary Position \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship/Phone Number \_\_\_\_\_

High School Graduation Year \_\_\_\_\_

**Disabilities accommodated with advanced (4-6 weeks) notification.**