

# Apple Hill Center for Chamber Music Emergency Contact Form 2010

I authorize emergency and non-emergency medical care to be provided in the event of a health problem or injury occurring during my stay at Apple Hill Center for Chamber Music.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Parent or guardian sign if participant is under 18

## PARTICIPANT (Please print)

NAME: \_\_\_\_\_ SESSION(S): I II III IV V  
Last First M.I. (CIRCLE)

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

Name of Parent or Guardian(s): \_\_\_\_\_

## EMERGENCY CONTACT (Please print)

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_  
Last First M.I.

ADDRESS: \_\_\_\_\_  
Street City State Zip

PHONE: HOME: \_\_\_\_\_ CELL: \_\_\_\_\_

WORK: \_\_\_\_\_ OTHER: \_\_\_\_\_

RELATION: \_\_\_\_\_ EMAIL: \_\_\_\_\_

## INSURANCE INFORMATION (Please print)

**I currently do NOT have medical insurance.**

**I currently have medical insurance:**

MEDICAL INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS OF COMPANY: \_\_\_\_\_  
Street City State Zip

PHONE: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

NAME OF PRINCIPAL (family member) INSURED: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_  
Last First M.I.

ADDRESS: \_\_\_\_\_  
Street City State Zip

FAMILY DOCTOR PHONE: 1. \_\_\_\_\_ 2. \_\_\_\_\_