NAME:

Miss Georgetown Fair Pageant Contestant
Medical/Dental Information

MEDICAL INSURANCE

( ) The Contestant has medical insurance. Birthdate:
Insurance Provider/HMO Name:
Group or Policy Number
Policy Holder Name:
Employer or Company Name (if group plan):

( ) The Contestant does not have medical insurance.
I will take full financial responsibility for medical treatment deemed necessary.

NAME: **PHONE NUMBER:**

DENTAL INSURANCE

( ) The Contestant has dental insurance.
Insurance Provider/HMO Name:
Group or Policy Number
Policy Holder:
Company:

( ) The Contestant does not have dental insurance.
I will take full financial responsibility for dental treatment deemed necessary.

NAME: **PHONE NUMBER:**

IF THE CONTESTANT IS UNDER THE AGE OF 18, THIS MUST BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN.

I certify the policy named above is now in force and will be maintained through August 12, 2008. I understand that contestants are responsible for all medical/dental expenses incurred during the time in which they participate in the Miss Georgetown Fair Pageant competition activities as well as traveling to or from the event; and agree to release the Georgetown Fair Pageant, the Georgetown Fair Board, staff or Volunteers from any loss, damage or liability or injury, however caused, arising from participation in the Miss Georgetown Fair Pageant, Further, I certify that the medical information given above is true and accurate.

Contestant Signature and Date **Parent/Guardian Signature and Date**

In the event of accident, injury, or illness of the aforementioned contestant, I the undersigned, do hereby authorize the Board, Staff and Volunteers of the Miss Georgetown Fair Pageant and the Georgetown Fair to provide emergency medical treatment; and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any registered medical or dental provider. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned medical or dental provider in the exercise of his best judgment may deem advisable. It is understood that effort shall bemade to contact the listed emergency contact prior to rendering treatment to the patient, but that any of the above treatment will not be withheld of the undersigned cannot be reached.

Contestant's Signature and Date **Parent Signature and Date**

NAME: