

His/her physician is:
Name:
Address:
Telephone (include area code):

Medical Insurance Company *
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number:

Dental Insurance Company *
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number:

**\*This insurance is not required. However, the information provided may be required to obtain non-emergency care.**

**PRIVACY ACT NOTIFICATION**

Under the authority of 5 U.S.C. Sec. 301, the information regarding your child's/ward's health, medical condition and treatment is requested in order to verify any need to administer medication and to enable medical/dental personnel to diagnose and treat any emergency condition which may arise during training. Pursuant to the Privacy Act, 5 U.S.C. Sec. 552, the requested information will not be divulged without your written authorization to anyone other than NJROTC area personnel involved with administration of NJROTC activities and medical/dental personnel requiring the information in order to effectively treat any medical/dental problem which may arise. Disclosure is voluntary; however, failure to provide the requested information will preclude your child's/ward's participation in the training.

Signature of Parent or Guardian:
Address:
City: State: Zip:
Telephone (include area code):