



PLEASE RETURN BY APRIL 1st TO:
WINTER (September 1 - May 15)
3 New King Street, White Plains, NY 10604
p: 914-437-7200 f: 914-422-3635

SUMMER (May 16 - August 31)
700 Churchill Street, Pittsfield, MA 01201
p: 413-447-8900 / 800-494-6238
f: 413-447-8905

INSURANCE AND CREDIT CARD FORM

To be completed by parents for ALL campers. One per camper.

Please return this form by April 1st.

Camper's Name \_\_\_\_\_ Session \_\_\_\_\_

(Please Print or Type)

Dear Parents,

Insurance information (medical and prescription) is required to be on file for each camper along with credit card information. Camp Winadu will charge your credit card only if camp incurs incidental medical expenses for your child. We will share insurance and credit card information with CVS/pharmacy in Pittsfield, MA should your child require their service.

INSURANCE INFORMATION

I ATTACHED A COPY OF MY CHILD'S MEDICAL AND PRESCRIPTION INSURANCE CARDS (FRONT AND BACK) TO THIS FORM. (REQUIRED)

If we do not have a copy of your insurance information at the time the prescription is filled or at the time of your child's appointment, the full amount will be charged to your credit card. You will be responsible for submitting a reimbursement claim to your insurance company for the charges.

Is your son covered by family medical insurance? Yes No

Insurance Carrier and Plan Name: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Social Security Number of policy holder or Insurance ID Number: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

CREDIT CARD INFORMATION

Visa Mastercard

Cardholder's Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Card #: \_\_\_\_\_ Security code: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

If your child takes daily medications (prescription/non-prescription/vitamins), please complete the CVS/Pharmacy Medication Form enclosed by April 1st.