



FAV GLAM GIRLS MEDICAL INFORMATION FORM

FAV Glam Girls Name:

FAV Glam Girls Title:

Today's Date:

Email:

Address:

City:

State:

Zip Code:

Phone Number:

Birthday: (month/day/year)

Emergency Contact:

Relationship:

Phone Number:

Current Physician:

Phone Number:

List any medications currently taking:

List any allergies to medications (e.g., penicillin):

Please list Medical Insurance Information:

I do not have Health Insurance but agree to pay any fees.

Company:

Address:

City:

State:

Zip Code:

Policy Number:

Group Number:

PARENTAL/GUARDIAN CONSENT FOR MEDICAL DIAGNOSIS, TREATMENT, AND BILLING OF INSURANCE

(Parental signature needed for minors and contestants who are on their parent's Insurance)

Parent/Guardian must check box below:

I hereby consent to allow The FAV Group, Inc. and staff to select a hospital, clinic, or other medical facility that shall be authorized to diagnose and treat the FAV Glam Girl named below for any medical problem that may occur during her stay at THE MISS VIRGINIA USA® / MISS VIRGINIA TEEN USA® Pageant and FAV Glam Girl Experience.

In addition, I hereby release The FAV Group, Inc., and staff from all liability therefrom and give permission to those granting services to bill my Insurance company listed for all services rendered.

If the contestant does not have medical insurance, or the medical provider does not accept her specific insurance, the payment responsibility is that of the parent/guardian.

FAV Glam Girl Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____