

Program _____

Dates Attending _____

MEDICAL TREATMENT AUTHORIZATION FOR MICHIGAN STATE UNIVERSITY

Your child will be involved in a Michigan State University program on the above date(s). This form must be completed and signed by a parent or guardian to give a medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated only if the situation is urgent and does not permit delay.

Participant's full legal name:

Last First M.I.

Birth date: _____

Parent phone: day () _____ evening: () _____

Mailing Address: _____

Primary care physician's name: _____

Physician's phone: _____

Physician's address: _____

HEALTH INSURANCE INFORMATION:

Policy holder's name and relationship to participant _____

Policy holder's address: _____

Please attach a photocopy of both sides of your insurance card **OR** complete the information requested below.

Insurance company name and address:

Insurance company phone number: (____) _____

All policy numbers (please identify): _____

If you have HMO insurance, please list the emergency treatment authorization phone number: (____) _____

Employer's name and address:

Business phone (____) _____

INFORMATION NEEDED ABOUT PARTICIPANT: Please check yes or no. If yes, explain below or on another sheet if you need more room.

Does the participant have any chronic health problem or illness? **YES** **NO** _____

Does he or she have any acute illness now? _____

Has the person been treated recently for some medical problem? _____

Does he or she have any allergies? _____

Does he or she have any allergies to medication or local anesthetics? _____

Date of his or her last tetanus shot _____

List any medications he or she is now taking for treatment of any medical problem. _____

OFFICIAL AUTHORIZATION FOLLOWS:

I (parent or legal guardian), _____, recognize that while attending this program, medical treatment on an emergency basis may be necessary for my child, and I further recognize that the program director may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the circumstances and to assume the expenses of such care. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature of Parent/Guardian or of participant aged 18 and up _____

Date _____