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:

_____ Birth date: _____

Last First M.I.

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.

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