MEDICAL INFORMATION AND RELEASE FORM – MINOR (INTERNATIONAL CAMP)

Minor's Name
Address:
City: State: Zip:
Telephone Number: Birthdate:
Gender:

Parent or Guardian Name:
Address:
City: State: Zip:
Telephone Number: email:

Emergency Contact Name (other than parent or guardian):
Address:
City:
Telephone Number: email:

Physician Name: Dentist Name:
Telephone Number: Telephone Number:

Allergies:
Current Medications and dosage:
Blood Type:
Date of Last Tetanus/Diphtheria Vaccinations:
Special Health Needs or Concerns:

Health Insurance Carrier Name: Phone Number:
Policy Holder Name: Policy Holder Date of Birth:
Policy Number: ID Number:

EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent or legal guardian of do hereby authorize emergency medical or surgical treatment and hospitalization if necessary for the above named minor. The University of Texas at Dallas and its designated representatives may consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered to upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization. The effective dates for this authorization are through

By signing this authorization, I represent to The University of Texas at Dallas that I have legal authority to provide consent for this minor child.

Signature of Parent or Guardian Date