

## Medical Authorization and Consent to Medical Treatment Form

### Part 1: Student Information: To be completed by parent/guardian.

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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

Birth date: \_\_\_\_\_ Gender (circle one) M F Age: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Cell Phone/Pgr: \_\_\_\_\_ Cell Phone/Pgr: \_\_\_\_\_

**Part 2: Emergency Contact Information:** Please list two people, other than parent/guardian listed above, who we may contact in case of an emergency if parents/guardians cannot be reached. At least one contact must be in the U.S.

Name and relationship to student: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Name and relationship to student: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**Part 3: Insurance Information:** Students should be covered by their family's medical insurance policy. Union College does not provide medical insurance of any kind. Local providers may require that you pay them directly at the time of service and then file for reimbursement with your insurance company. If you do not have insurance, write "none."

Medical insurance provider: \_\_\_\_\_

Policy/Group number: \_\_\_\_\_

Address of insurance provider: \_\_\_\_\_

Name of policy holder: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Prescription Card #: \_\_\_\_\_

Employer of policy holder: \_\_\_\_\_

### **Part 4: Medications Information:** Please check one:

My child takes regular medications (which may include prescription medicines, over-the-counter medicines, vitamins, or herbal supplements). I understand that these medications will be dispensed by Union College Health Services staff only and that my child may not keep medications with him or her (with the exception of inhalers, epi-pens, insulin, and topical medications). I understand that no medication will be administered without a physician's signature, so I will have our physician authorize Union College Health Services to dispense the medications.

My child does not take regular medications at this time. If he or she will need to bring an medicines to Union College, I understand that I will need to get an authorization from my physician and that all medications will be turned over to and dispensed by Union College Health Services staff only.

**Part 5: Medical History:** Please check all that apply to your child and give necessary details below:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ear/sinus infections      | <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Musculoskeletal disorders |
| <input type="checkbox"/> Migraines/headaches       | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Eczema/skin disorder      |
| <input type="checkbox"/> Hearing/vision impairment | <input type="checkbox"/> Gastrointestinal disorders | <input type="checkbox"/> ADD or ADHD               |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Urinary tract infections   | <input type="checkbox"/> Depression/anxiety        |
| <input type="checkbox"/> Bronchitis/pneumonia      | <input type="checkbox"/> Enuresis                   | <input type="checkbox"/> Eating disorder           |
| <input type="checkbox"/> Heart defect/disease      | <input type="checkbox"/> Neurologic disorder        | <input type="checkbox"/> Learning disability       |
| <input type="checkbox"/> Hemophilia/blood disorder | <input type="checkbox"/> Seizures/fainting          | <input type="checkbox"/> Other                     |

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Allergies to food medications, insect stings, etc.: \_\_\_\_\_

Does your child carry an epi-pen for allergies? \_\_\_\_\_

Operations or serious illnesses: \_\_\_\_\_

Under care of psychologist, psychiatrist, or counselor: \_\_\_\_\_

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**Part 6: Permission to Treat:** This is to authorize the medical personnel of the Event site and/or off-campus medical facilities to provide necessary medical care to your child.

In the event of an emergency, I consent for medical personnel of Union College or the Event site or physicians of the nearest or most appropriate hospital to perform any necessary emergency treatment, including surgery, injection, or other procedures requiring the use of a local or general anesthetic. This authorization shall be in effect while my child is a student at the Event. I understand that I am fully responsible for all medical costs incurred by my child.

\_\_\_\_\_  
Signature of parent/guardian Date

\_\_\_\_\_  
Signature of parent/guardian Date