



AUTHORIZATION FORM
Grandparents University, June 30 – July 2, 2015

CHILD MEDICAL FORM

This form must be completed and signed by a parent or legal guardian for each child before he or she can participate in Grandparents University at MSU. Complete one form for each child participating and duplicate as needed.

This form entails permission to treat the participant for 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.**

Child Participant's Full Name	
Birth Date	
Primary Physician's name	Physician's phone
HEALTH INSURANCE INFORMATION:	
Policy holder's name and relationship to participant	
Policy holders address	
Please complete the information requested here:	
Insurance company name and address	
Insurance company phone number	All policy numbers (please identify)
If you have HMO insurance, please list emergency treatment authorization phone number	
Employer's name and address	
INFORMATION NEEDED ABOUT PARTICIPANT:	
Please check yes or no. If yes, explain below .	
<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Does the participant have any chronic health problem or illness?</p> <p><input type="checkbox"/> <input type="checkbox"/> Does he or she have any acute illness now?</p> <p><input type="checkbox"/> <input type="checkbox"/> Has the participant been treated recently for a medical problem? If so, specify: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> List any medications he or she is now taking _____</p> <p><input type="checkbox"/> <input type="checkbox"/> If the participant has any allergies to medication or local anesthetics, specify: _____</p> <p>_____</p> <p>Specify any other allergies _____</p> <p>Date of his or her last tetanus shot _____</p>	
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. I further recognize that staff 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 authorize the medical facility to release any and all information required to complete insurance claims and authorize insurance payment directly to the medical facility.	
Signature _____	Date _____
(Parent or guardian must sign here)	
Name of Parent or Legal Guardian (please print): _____	
Home Mailing Address _____	
E-mail Address _____	
Daytime Phone _____	Evening Phone _____
ELECTRONIC FORM gpu@msu.edu	