Parental/Guardian Authorization for Treatment of Minors (under age 18)

Section 1—TREATMENT AUTHORIZATION
I authorize the provision of medical or hospital care deemed necessary for:

Name: _____ ☐Male ☐Female
First Middle Last

Date of Birth: / /

In the event an illness or injury occurs during his or her volunteer service to Florida Atlantic University, I further authorize each of the following:

- I grant permission to the treating physician or other health care providers to employ such diagnostic procedures and medical treatment as deemed necessary.
- I authorize all medical care units to release medical record information to the University's workers' compensation health care provider and insurance carrier in order to process claims.

I understand that I am financially responsible for charges not covered by the University or insurance and hereby guarantee full payment to the physicians or health care units.

Section 2—PHYSICIAN/EMERGENCY CONTACT INFORMATION
Family Physician
Name: _____ Phone: _____
Address: _____

Emergency Contact
Name: _____ Phone: _____
Address: _____

Section 3—PARENT/GUARDIAN INFORMATION

Name of Parent or Guardian: _____
Phone: (Home) _____ (Work) _____ (Cell) _____
Address: _____
Signature: _____ **Date:** _____

Name of Parent or Guardian: _____
Phone: (Home) _____ (Work) _____ (Cell) _____
Address: _____
Signature: _____ **Date:** _____

Section 4—TO BE COMPLETED BY THE DEPARTMENT *Department documentation for telephone authorization*
Person Contacted: _____ Phone: _____
Relationship to Volunteer: _____
Witnesses: _____
Description: _____
_____
_____
Date: _____ Time: _____