UNIVERSITY OF NOTRE DAME
HEALTH INFORMATION AND CONSENT FOR EMERGENCY MEDICAL TREATMENT FORM FOR MINORS
FORM 3a (Visitors or Volunteers)

Research Department: _____

Name of Minor Child: _____ Birth Date: _____

Permission for Treatment: The health history provided on this form is correct to the best of my knowledge. By my signature below, I hereby grant permission and authorize the provision of emergency medical treatment for minors/students who become ill or injured while participating in a University of Notre Dame du Lac sponsored Program and when parents or guardians cannot be reached.
Release of Information: By my signature below, I authorize the University of Notre Dame to release medical information regarding the above named minor/student to any person or entity to whom the University of Notre Dame refers the minor/student for medical treatment.

TO GRANT CONSENT

I, _____ of _____
(Name of Parent/Legal Guardian) (City)
_____, _____, do hereby state that I am the
(County) (State)
parent or legal guardian of: _____, a minor.
(Name of Child)

Should an emergency arise while my child is under the supervision of the staff of The University of Notre Dame du Lac, I do hereby authorize the staff to obtain medical attention for my child. I do hereby give consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, blood transfusion and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine during the program period. All such treatment shall be at my expense, and I agree to reimburse the University or its representatives for any expenses that they or any of them might incur on account of my child's condition or treatment. This consent shall not give rise to, and is not intended to give rise to a legal duty owed by the University to my child. I do hereby release and forever discharge the University of Notre Dame du Lac and its employees, agents, officers, trustees, affiliates and representatives from any and all liability of any kind for any claim, demand, action, cause of action, expense (including hospital and medical expenses), judgment or cost, including without limitation attorneys' fees, co-pays or deductibles, which arise out of or relate in any manner to the exercise of authority or judgment pursuant hereto, or to the securing, oversight, administration or supervision of medical or other care or treatment on behalf of my minor child at any time or any travel incident thereto.

♦ Family Doctor: _____ Phone: _____

♦ Family Dentist: _____ Phone: _____

♦ Medical Insurance: _____, _____, _____
(ID Number) (Group Number) (Member's Name)

♦ Medical History: Allergies, if any, including medication and foods: _____
_____

♦ Chronic or existing diseases or medical problems (e.g. diabetes, epilepsy): _____

♦ Medicines your child is now taking and dosage: _____

♦ Date child received last Tetanus injection or booster (if known): _____

♦ Any physical restrictions: _____

I can be reached at the following phone numbers(s) in an emergency:
_____, (____) _____
(Name and Location) (Phone)
_____, (____) _____
(Name and Location) (Phone)

_____ Dated _____
(Signature of Parent/Legal Guardian)