MEDICAL TREATMENT AUTHORIZATION FORM

Grandparents University, June 24 – June 26, 2014

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 attach a photocopy of both sides of your insurance card (preferred) OR 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 or on the back side of this sheet.**

Yes No

☐☐ Does the participant have any chronic health problem or illness?

☐☐ Does he or she have any acute illness now?

☐☐ Has the participant been treated recently for a medical problem? If so, specify: _____

☐☐ List any medications he or she is now taking_____

☐☐ If the participant has any allergies to medication or local anesthetics, specify: _____

_____

Specify any other allergies_____

Date of his or her last tetanus shot _____

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 _____

Sign and return to:
Grandparents University, c/o University Advancement, MSU Alumni Association, 535 Chestnut Road, Room 300
East Lansing, MI 48824