

ISU Medical Information - Parental Medical Emergency Permission

Participant's Name _____
Permanent Address _____
City, State, Zip _____

Date of Birth _____ Gender _____
Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First

Name _____
Relationship to Participant _____
Daytime Phone _____
Evening Phone _____
Name of Family Doctor/Office Number _____
Name of Dentist/ Office Number _____

Backup Contact (Relative or Friend)

Name _____
Relationship to Participant _____
Daytime Phone _____
Evening Phone _____

INSURANCE POLICY INFORMATION

The above-named participant is covered by health insurance. Yes No*
*If no, initial this line stating that you do not have health insurance and are aware that ISU does **not** carry any health insurance for you. _____

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____
Address _____ Relationship to Participant _____
City, State, Zip _____ Occupation _____
P.H.'s Employer's Name/Address _____

Insurance Company Name _____
Policy # _____ Plan # _____

TO BE READ AND SIGNED BY PARTICIPANT'S PARENT: MEDICAL EMERGENCY PERMISSION

If an injury or other medical condition occurs or arises, I hereby give permission to Iowa State University to provide routine first aid and seek emergency treatment including x-rays or routine tests. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. I understand that I am financially responsible for charges to the attending physicians or health care unit. In the event of an emergency where I cannot decide for my child, I give permission to the physician/hospital selected by Iowa State University to secure and administer treatment for my child, including hospitalization.

Parent's Name (please print)

Date

Signature of Parent or Guardian (if under 18)

If you cannot sign this section of the form for any reason, contact the Office of Risk Management regarding a legal waiver