THE UNIVERSITY OF TEXAS AT DALLAS

MEDICAL INFORMATION AND RELEASE FORM – MINOR (DOMESTIC CAMP)

Minor's Name
Address:
City: State: Zip:
Telephone Number: Birthdate
Gender:

Parent or Guardian Name:
Address:
City: State Zip
Telephone Number email:

Emergency Contact Name (other than parent or guardian):
Address:
City:
Telephone Number: email:

Physician Name: Dentist Name:
Telephone Number: Telephone Number:

Allergies: Blood Type:
Current Medications and dosage: Date of Last Tetanus/Diphtheria Vaccinations:
Special Health Needs or Concerns:

Health Insurance Carrier Name: Phone Number
Policy Holder Name: Policy Holder Date of Birth
Policy Number: ID Number:

EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent or legal guardian of do hereby authorize emergency medical or surgical treatment and hospitalization if necessary for the above named minor. I understand that an attempt will be made to contact me, or the named emergency contact, before taking this action. If I or the emergency contact, cannot be reached, The University of Texas at Dallas and its designated representatives may consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered to upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization. The effective dates for this authorization are through

By signing this authorization, I represent to The University of Texas at Dallas that I have legal authority to provide consent for this minor child.

Signature of Parent or Guardian Date