THE UNIVERSITY OF TEXAS AT DALLAS

MEDICAL INFORMATION AND RELEASE FORM – MINOR

MINOR'S NAME: ______________________________
ADDRESS: ______________________________
____
PHONE NUMBER: ____________ **DOB:** ________ **GENDER:** ________
DESCRIPTION OF ACTIVITY OR TRIP: ______________________________
____
LOCATION: ______________ **DATE(S):** ______________

PARENT/GUARDIAN: ______________________________
ADDRESS: ______________________________
____
PHONE NUMBER: ____________ **EMAIL:** ______________
EMERGENCY CONTACT (other than parent/guardian): ______________
ADDRESS: ______________________________
PHONE NUMBER: ______________ **EMAIL:** ______________

PHYSICIAN: ______________ **PHONE NUMBER:** ______________
DENTIST: ______________ **PHONE NUMBER:** ______________

ALLERGIES(if none, put n/a): ______________ **BLOOD TYPE:** ________
DATE OF LAST TETANUS/DIPTHERIA VACCINATIONS: ______________
CURRENT MEDICATIONS AND DOSAGE (if none, put n/a): ______________
SPECIAL HEALTH NEEDS/CONCERNS: ______________
HEALTH INSURANCE CARRIER: ______________
PHONE NUMBER: ______________
POLICY HOLDER NAME & DATE OF BIRTH: ______________
POLICY NUMBER: ______________ **ID NUMBER:** ______________

EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent or legal guardian of the above-referenced minor participant, 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 the above-named minor participant 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. This authorization is effective through the dates listed above. 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:** ____________