SAINT MARTIN'S UNIVERSITY

HEALTH INFORMATION AND CONSENT FOR EMERGENCY MEDICAL TREATMENT FORM

Minors

Program Attending: _____ Dates of Program: _____

Name of Student or 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 Saint Martin's University sponsored Program and when parents or guardians cannot be reached. I hereby grant permission to program staff to administer insect repellant and /or sun screen as needed to the above named child. I understand that it is my responsibility to provide my child with adequate sun/bug protection and any application made available by program staff is a supplemental precaution.

Release of Information: By my signature below, I authorize Saint Martin's University to release medical information regarding the above named minor/student to any person or entity to whom Saint Martin's University 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 parent or
(County) (State)

legal guardian of: _____, a minor child.
(Name of Child)

Should an emergency arise while my child is under the supervision of the staff of Saint Martin's University, 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 Saint Martin's University 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 attorney's 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) (Insurance 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: _____
- My child has been instructed on how to self-administer their medication and will have it with them at all times, in the medication's original container, labeled with the prescribing physician, dosage and expiration date.
- If over-the counter medication is sent with the minor above manufacturer's recommendations, a physician's note must accompany medication.
- I can be reached at the following phone numbers(s) in an emergency listed below:

_____, (____) _____
(Name and Location) (Phone)

_____, (____) _____
(Name and Location) (Phone)

_____ Dated _____
(Signature of Parent/Legal Guardian)

Please use the reverse side of this form for any additional conditions or medications