THE UNIVERSITY OF TEXAS AT AUSTIN

AUTHORIZATION FOR MEDICAL EMERGENCY MEDICAL TREATMENT – ADULT

I. **MEDICAL INFORMATION** (please type or print legibly)

a. Name _____

Address _____

Telephone Number: Day (____)_____ Night (____)_____

b. Name of Nearest Relative _____

Address _____

Telephone Number: Day: (____)_____ Night (____)_____

c. Physician's Name _____

Address _____

Telephone Number: Day: (____)_____ Night (____)_____

d. Dentist's Name _____

Address _____

Telephone Number: Day: (____)_____ Night (____)_____

e. Health Insurance Company Name _____

Policy Number _____ Telephone (____)_____

f. Allergies _____

g. Current Medications _____

h. Special Health Needs _____

II. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned, d hereby authorize The University of Texas at Austin and its agents or representatives to consent, on my behalf, to any medical/hospital care or treatment (including locations outside the U.S) to be rendered 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 of this authorization are _____ to _____ 20_____.

I am eighteen years of age or older, have read the above authorizations, and confirm that the information contained therein is true and accurate.

AGREED TO AND ACCEPTED BY:

_____ _____.

Signature of Individual Providing Authorization Date