AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT – MINOR

I. MEDICAL INFORMATION (please type or print legibly)

a. Name of Minor ____

b. Name of Parent/Guardian ______________________________________

Address ____

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

c. Minor's Physician ____

Address ____

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

d. Minor's Dentist ____

Address ____

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

e. Health Insurance Company Name _______________________________

Policy Number ________________ Telephone (____)_____________

f. Minor's Allergies ____

g. Minor's Current Medications ___________________________________

h. Minor's Special Health Needs __________________________________

II. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent or legal guardian of _____________________ do hereby authorize The University of Texas at Austin and its designed representatives to consent, on my behalf, to any 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 date of this authorization is _________________________.

AGREED TO AND ACCEPTED BY:

____ ________________________

Signature of Parent or Guardian Date