University of Nebraska Kearney

HEALTH INFORMATION AND CONSENT FOR EMERGENCY MEDICAL TREATMENT FORM

Should an emergency arise while I am under the supervision of the staff of University of Nebraska, Kearney, I do hereby authorize the staff to obtain medical attention for me. I do hereby give consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to myself under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine during the program period. I do hereby release and forever discharge the University of Nebraska, Kearney 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, judgment or cost, including without limitation attorney's fees, 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 me at any time or any travel incident thereto.

Family Doctor:_____ Phone: _____

Family Dentist:_____ Phone:_____

Medical Insurance:_____ / _____ / _____
(ID Number) (Group Number) (Member's Name)

Medical History: Allergies, if any, including medication and foods:_____

_____

_____

_____

Chronic or existing diseases or medical problems (e.g. diabetes, epilepsy):_____

_____

_____

_____

Medicines you are now taking and dosage:_____

_____

_____

Date you received last Tetanus injection or booster (if known):_____

Any physical restrictions:_____

_____

_____

Name, and phone number of individuals we can contact in an emergency:

Name:_____ Phone:_____

Name:_____ Phone:_____

_____ _____
Signature of Participant *Date*

_____ _____
Signature of Parent/Guardian *Date*