University of Nebraska at Kearney
HEALTH INFORMATION AND CONSENT FOR EMERGENCY MEDICAL TREATMENT FORM
Minors

Program Attending: _____ Dates of Program: _____

Student Name: _____ Birthdate: _____

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 University of Nebraska at Kearney sponsored Program and when parents or guardians cannot be reached.

Release of Information: By my signature below, I authorize the University of Nebraska at Kearney to release medical information regarding the above named minor/student to any person or entity to whom University of Nebraska at Kearney refers the minor/student for medical treatment.

TO GRANT CONSENT

I, (we) _____ of _____
(Name of Parent(s)/Legal Guardians(s) (City)
_____, _____, do hereby state that I (we) are the
(County) (State)
Parent or legal guardians(s) of: _____, a minor.
(Name of Child)

Should an emergency arise while my child is under the supervision of the staff of University of Nebraska at Kearney, I, (we) do hereby authorize the staff to obtain medical attention for my child. I, (we) do hereby give consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, 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. I (we) do hereby release and forever discharge the University of Nebraska at 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 my child 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 your child is now taking and dosage:_____
- Date child received last Tetanus injection or booster (if known): _____
- Any physical restrictions: _____

I, (we) can be reached at the following phone numbers(s) in an emergency:
_____, (____) _____
(Name and Location) (Phone)
_____, (____) _____
(Name and Location) (Phone)

_____ Dated _____
(Signature(s) of Parent(s)/Legal Guardian(s))