MEDICAL INFORMATION AND RELEASE FORM – MINOR

**Minor’s Name:**  **Address: Phone: DOB: Gender:**

**Description of Activity or Trip: Location: Date(s):**

**Parent/Guardian: Address: Phone: Email: Emergency Contact (other than parent/guardian): Address: Phone: Email:**

**MEDICAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| **Physician:** |  | **Phone:**  |
| **Dentist:** |  | **Phone:**  |

**Allergies (if none, put n/a): Blood Type: Date of Last Tetanus/Diphtheria Vaccinations: Current Medications and Dosage (if none, put n/a): Special Health Needs or Concerns: Health Insurance Carrier: Phone: Policy Holder Name & Date of Birth: Policy #: ID #:**

**EMERGENCY MEDICAL AUTHORIZATION**

I, the undersigned parent or legal guardian of the above-referenced minor participant, do hereby authorize emergency medical or surgical treatment and hospitalization if necessaryfor the above named minor. I understand that an attempt will be made to contact me, or the named emergency contact, before taking this action. If I, or the emergency contact, cannot be reached, The University of Texas at Dallas and its designated representatives may consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered to the above- named minor participant 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. This authorization is effective through the dates listed above. By signing this authorization, I represent to The University of Texas at Dallas that I have legal authority to provide consent for this minor child.

Signature of Parent/Guardian: Date: