New friends and memories to last a lifetime are just part of what your child will experience on the Bloomington campus of Indiana University.

Whether or not this is your son's or daughter's first time away from home, we know you still worry. What happens if he or she gets sick or injured and you can't be reached right away?

At Indiana University, we share your concern. That's why we ask that you fill out this form and return it as soon as possible to the director of the program in which your child is enrolled. If he or she gets sick or injured, this form provides vital medical information. It does not mean that every effort won't be made to contact you first, but it does mean that your child can still be treated quickly even if you can not be reached.

Remember... this form will probably never be used. Safety is our number one priority at IU, especially where children are concerned. But peace of mind is worth the few minutes it takes to complete this form. Please do it today, then relax while your child looks forward to their time at IU!

Consent for Medical Treatment (Minors Only)

I, ____________________________, being the parent or legal guardian of ____

grant the following authorization for medical and/or surgical treatment of this minor by a health care professional should

the need arise while he/she is attending ____ for the time

period starting ____________________________ and ending ____________________________.

*Please complete **ONE** of the following:*

1. I grant permission to the directors, assistants, or other persons responsible for his/her care to act on my behalf for said minor in granting permission for evaluation and treatment of medical or psychological problems. I understand that should a major medical or psychological problem arise, reasonable attempts will be made to notify me by telephone. In the event that I cannot be reached, I give my consent to such medical treatment as deemed necessary, including surgery, x-ray examinations, and anesthesia to be rendered to said minor by a licensed physician or nurse.

Date _________________ Signature ____

2. I do not wish medical care of any kind, except in case of an emergency.

Date _________________ Signature ____

3. I authorize limited medical care as follows ____

____

____ to be provided.

Date _________________ Signature ____

Medical Information (All Participants)

Participant's name ______________________________ Social Security Number _______ - _______ - _______

Age ___________ Birthdate ______________________ Date of last Tetanus Toxoid ____________________

Past health/injuries ______________________________ Present health ____________________________

____ Allergic reactions __________________________

____ Present medication _________________________

Other information that would be useful in the event medical treatment is necessary ____________________________

____

Contact People (All Participants)

In an emergency, parents or legal guardians can be reached as follows:

Name __________ Relationship to minor __________
Address __________ Daytime phone __________
City/State/Zip __________ Evening phone __________

Name __________ Relationship to minor __________
Address __________ Daytime phone __________
City/State/Zip __________ Evening phone __________

Name __________ Relationship to minor __________
Address __________ Daytime phone __________
City/State/Zip __________ Evening phone __________

If other information would be helpful in contacting you, please indicate. __________

Insurance Information (All Participants)

Parents or legal guardians are responsible for the cost of a minor's medical treatment. When available, insurance information will be processed by the health facility performing the treatment, otherwise you will be contacted for payment by cash, check or credit card.

Insurance company __________ Address __________
City/State/Zip __________
Policyholder's name __________
Policy number __________
(Identification number, benefit code, account number, etc.)

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Consent for Medical Treatment