RISK MANAGEMENT SERVICES

Programs for Minors
Medical Information Form

University of North Texas at Dallas

NAME OF PROGRAM: _____

NAME OF PROGRAM PARTICIPANT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ Sex: _____

*Optional Information (next two questions): *HEIGHT: _____ *WEIGHT: _____

PARENT (or guardian) NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: ( ) _____ EMERGENCY PHONE: ( ) _____

EMERGENCY CONTACT NAME: _____ RELATION: _____

CELL PHONE: ( ) _____ EMERGENCY PHONE: ( ) _____

PRIMARY CARE PHYSICIAN: _____ PHONE: ( ) _____

DO YOU HAVE HEALTH INSURANCE? YES: _____ NO: _____

NAME OF CARRIER	POLICY NUMBER	Name of Primary Insured
_____	_____	_____

A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD MUST BE ATTACHED.

Does the Program Participant have any chronic or acute medical problems? YES: _____ NO: _____

Please explain: _____

_____

List any allergies to food, pollen, or medicine: _____

List any medications being taken at present time: _____

List any other conditions we should be aware of: _ _____

My child has permission to attend a Program for Minors sponsored by the University of North Texas at Dallas. I fully realize that injury or illness to my child may result from or during participation in the program. In case of injury or illness, I give permission for my child to be given medical treatment as deemed appropriate. I further give permission for the information provided on this form to be shared with appropriate medical personnel. I further give permission for and grant authority to the program representatives to sign on my behalf. I understand and acknowledge that I will be responsible for any medical bills incurred by my child at the University of North Texas at Dallas, at a local hospital, or elsewhere.

Signature: _____ Date: _____