AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT – MINOR

I. Medical Information (Please type or print legibly)

a. Name of Minor ______________________________
(last, first, middle)

b. Name of Parent/Guardian ______________________________
(last, first, middle)

Address ______________________________

Telephone Number Day (___) __________ Night (____) ___________

c. Minor's Physician ______________________________

Address ______________________________

Telephone Number Day (___) __________ Night (____) ___________

d. Minor's Dentist ______________________________

Address ______________________________

Telephone Number Day (___) __________ Night (____) ___________

e. Health Insurance Company Name ______________________________

Policy Number ________________________ Telephone (____) ______________

f. Minor's Allergies ______________________________

g. Minor's Current Medication ______________________________

h. Minor's Special Health Needs ______________________________

II. EMERGENCY MEDICAL AUTHORIZATION

I undersigned parent or legal guardian of ______________________________
(name of minor)

do hereby authorize The University of Texas of the Permian Basin and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment to be rendered to upon advice of ____________________________ any licensed physician. I agree to be responsible for all necessary
(name of minor)
charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

The effective dates of this authorization are ______________________________ to ______________________________

______________________________________ Date: ______________________________
(signature of Parent or Guardian)

(For persons less than eighteen years of age)

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