CONSENT FOR EMERGENCY MEDICAL TREATMENT OF A MINOR STUDENT

STUDENT INFORMATION

Name_____ Monroe ID _____

Permanent Address _____ Date of Birth _____ Sex_____

This form must be completed and signed by the legal guardian of the student. The information we ask you to provide is necessary in the event the student needs emergency medical treatment.

I, _____ (❑ Mother ❑ Father ❑ Legal Guardian) do, hereby voluntarily authorize Monroe College staff to seek medical treatment for my son/ daughter _____ as they see necessary at Metro Med, Sound Shore Medical Center of Westchester or any other nearby facility. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide Monroe College administration the authority to seek medical treatment for my child, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary.

It is understood that while the College makes an effort to secure quality emergency medical care for the student, the College, its trustees, officers, employees or agents, are not responsible for any harm to the student which results from the negligence of third parties in providing such care. It is understood that the College will attempt to communicate immediately with the student's parent or guardian to inform them of emergency measures. However, such communication is not pre-condition to the permission and authorization hereby above extended to the authorities of Monroe College to secure emergency medical treatment for the student. I accept full responsibility for payment of all services rendered and authorize any medical facility which renders service to release medical information necessary for the processing of insurance claims.

_____

Signature of Parent/ Guardian Print Name Date

MEDICAL INFORMATION

Allergies_____
_____
Medications_____
_____

EMERGENCY CONTACT

Name _____
Relation_____
Daytime Phone _____
Evening Phone_____

INSUREANCE POLICY INFORMATION

Health Insurance: Yes___ No____
Company and Policy #_____
Medications_____

PHYSICIAN'S INFORMATION

Physician's Nam_____
Phone_____