Washington State University
Cougar String Camp

Medical Treatment Authorization

I _____, the legal parent/guardian of (_____) (Participant name), hereby authorize and give my consent to Washington State University Health and Wellness Services, or any licensed medical professionals, to perform upon Participant any reasonably necessary or advisable medical treatment. In the event medical treatment is necessary, University authorities or licensed medical professionals will make a reasonable attempt to contact me before relying upon this authorization. If I cannot be contacted, I authorize WSU, its employees, and the treating licensed medical professionals to obtain or provide whatever medical treatment is deemed necessary for the Participant. This authorization is intended to cover minor and emergency treatment, surgeries, injections, blood transfusions, anesthetics, and operations and procedures.

This authorization does not entitle the licensed medical professional to render any medical or surgical treatment without Participant's personal consent, unless Participant is unable to give consent. This permission is good only while Participant is attending the Cougar String Camp, unless revoked by myself or Participant in writing and only until Participant has turned eighteenth years of age.

I understand that I will be responsible for any expenses in connection with Participant's attendance at the Cougar String Camp, including any medical treatment expenses.

AS CONSIDERATION FOR PARTICIPANT'S ENGAGEMENT AND PARTICIPATION IN THE COUGAR STRING CAMP, I AGREE THAT I HAVE READ THIS AGREEMENT AND THE ATTACHED MEDICAL INFORMATION AND RELEASE FORM, I AM SATISFIED THAT I UNDERSTAND ITS CONTENTS AND SIGNIFICANCE, AND AGREE TO ITS TERMS.

_____	_____
Signature of Parent or Guardian	Printed Name
_____	_____
Relation to Participant	Date

Cougar String Camp

Medical Information Form

Participant's Name _____ Birth Date _____

Parent/Guardian's Name _____

Parent/Guardian's Address _____

Day Phone _____ Evening Phone _____ Emergency Phone _____

Special Medical Conditions (attach additional page if necessary)

_____

Allergies to drugs: ____ Yes ____ No If yes, please list: _____

Allergies to foods: ____ Yes ____ No If yes, please list: _____

Allergies to bee stings that require medication ____ Yes ____ No

Special dietary restrictions _____

Other pertinent information (including medications the student is currently taking)

Insurance Company Name _____

Insurance Company Address _____

Policy Number _____ Group Number _____ Subscriber's Name _____

Family Physician _____ Phone number _____