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 eighteen 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 __________________________