Washington State University
Summer Musical Theatre 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 Musical Theatre 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
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 _______________________