**AUTHORIZATION FORM**

Grandparents University, June 27 – June 29, 2017

**CHILD MEDICAL FORM**

**This form must be completed and signed by a parent or legal guardian for each child before he or she can participate in Grandparents University at MSU. Complete one form for each child participating and duplicate as needed.**

This form entails permission to treat the participant for injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated **only if the situation is urgent and does not permit delay.**

| | |
|---|---|
| Child Participant's Full Name | |
| Birth Date | |
| Primary Physician's name | Physician's phone |
| **HEALTH INSURANCE INFORMATION:** | |
| Policy holder's name and relationship to participant | |
| Policy holders address | |
| **Please complete the information requested here:**<br>Insurance company name and address | |
| Insurance company phone number | All policy numbers (please identify) |
| If you have HMO insurance, please list emergency treatment authorization phone number | |
| Employer's name and address | |

**INFORMATION NEEDED ABOUT PARTICIPANT:**

Please check yes or no. **If yes, explain below .**

**Yes No**

☐☐Does the participant have any chronic health problem or illness?

☐☐ Does he or she have any acute illness now?

☐☐ Has the participant been treated recently for a medical problem? If so, specify: ___________________

☐☐ List any medications he or she is now taking___________________

☐☐ If the participant has any allergies to medication or local anesthetics, specify: ___________________

___________________

Specify any other allergies___________________

Date of his or her last tetanus shot ___________________

**OFFICIAL AUTHORIZATION FOLLOWS:**

I (parent or legal guardian), recognize that while attending this program medical treatment on an emergency basis may be necessary for my child. I further recognize that staff may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the circumstances, and to assume the expenses of such care. I authorize the medical facility to release any and all information required to complete insurance claims and authorize insurance payment directly to the medical facility.

**Signature**___________________Date___________________

(Parent or guardian must sign here)

## AUTHORIZATION FORM

Grandparents University, June 27 – June 29, 2017

Name of Parent or Legal Guardian (please print):______________________________________________

Home Mailing Address______________________________________________

E-mail Address______________________________________________

Daytime Phone ______________________ Evening Phone ______________________

**ELECTRONIC FORM**
**gpu@msu.edu**