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**GEORGIA STATE UNIVERSITY**

**EMERGENCY CONTACT, MEDICAL INFORMATION AND  
AUTHORIZATION FOR MEDICAL CARE**

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**Program Name:** \_\_\_\_\_

**Date(s) of Program:** \_\_\_\_\_

**Participant Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

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**Emergency Contact Information**

**Emergency contact name and phone number:** \_\_\_\_\_

**Relationship to Participant:** \_\_\_\_\_

**Backup emergency contact name and phone number:** \_\_\_\_\_

**Relationship to Participant:** \_\_\_\_\_

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**Health Insurance Information (if available)**

**Insurance Provider:** \_\_\_\_\_ **Insurance Phone Number:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Physician/Pediatrician Practice:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

(Note: Georgia State University does not offer any form of health, liability, or other types of insurance for participants. If available, please attach a copy of the front and back of your insurance card with this form.)

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**Medical Information**

1. Medical information we need to know about your child (current conditions, physical limitations, past injuries, etc.):

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2. Allergies (medications, stings, foods, iodine, latex, etc.):
3. Medications child is currently taking, dosage, and times taken:
4. Does your child need any accommodations to safely participate in the program? If yes, please explain.

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## Authorization for Program Staff to Administer Medication (if applicable)

**Medication:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_

**Instructions (when to give, whether to take with food, etc.):** \_\_\_\_\_

**Special Storage Instructions:** \_\_\_\_\_

I authorize the Program staff to administer my child the above-listed medication. I understand that medication, whether over-the-counter or prescription, must be kept in original containers with original label. When no longer needed, medications shall be returned to me whenever possible. If the medication cannot be returned, it shall be destroyed.

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## Authorization for Medical Treatment

I consent to medical and/or surgical care as may become necessary for the Participant's well-being, should the need arise, and I understand that I will be solely responsible for the the cost. I authorize the University to communicate in emergencies with the person(s) identified in my submission materials. I hold harmless and agree to indemnify the University from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment.

By signing this form, I agree that all information is accurate and current, that all important information is listed on this form, and to the best of my knowledge, my child is capable of participating safely in the Program. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program. I agree to notify the program of any changes in the above information as soon as possible.

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**Signature of Parent/Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_