

## Sam Houston State University

### **AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT- ADULT**

#### **I. MEDICAL INFORMATION** (please type or print legibly)

- a. Name \_\_\_\_\_  
(Last, first, middle)  
Address \_\_\_\_\_  
(Street or P.O. Box, city, state, zip code)  
Telephone Number: Day: \_\_\_\_\_ Night: \_\_\_\_\_
- b. Name of Nearest Relative \_\_\_\_\_  
(Last, first, middle)  
Address \_\_\_\_\_  
(Street or P.O. Box, city, state, zip code)  
Telephone Number: Day: \_\_\_\_\_ Night: \_\_\_\_\_
- c. Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
(Street or P.O. Box, city, state, zip code)  
Telephone Number: Office: \_\_\_\_\_ Emergency: \_\_\_\_\_
- d. Dentist's Name \_\_\_\_\_  
Address \_\_\_\_\_  
(Street or P.O. Box, city, state, zip code)  
Telephone Number: Office: \_\_\_\_\_ Emergency: \_\_\_\_\_
- e. Health Insurance Company Name \_\_\_\_\_  
Policy Number \_\_\_\_\_ Telephone: \_\_\_\_\_
- f. Allergies \_\_\_\_\_
- g. Current Medications \_\_\_\_\_
- h. Special Health Needs \_\_\_\_\_

#### **II. EMERGENCY MEDICAL AUTHORIZATION**

I, the undersigned, do hereby authorize Sam Houston State University and its agents or representatives to consent, on my behalf, to any medical/hospital care or treatment (including locations outside the U.S.) to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

The effective dates of this authorization are \_\_\_\_\_ to \_\_\_\_\_ 20\_\_\_\_.

I am eighteen years of age or older, have read the above authorization, and confirm that the information contained therein is true and accurate.

\_\_\_\_\_  
(Signature of Individual Providing Authorization) Date \_\_\_\_\_ 20\_\_\_\_.

*To be completed by persons eighteen years of age or older.*