



## MEDICAL AUTHORIZATION TO TREAT University (conducted/managed/operated)Programs

George Mason University requests the following information so that the Program staff can arrange for medical care in the event of an emergency. You are responsible for providing accurate and complete information.

Program/Camp Name: \_\_\_\_\_  
Date(s): \_\_\_\_\_ Location: \_\_\_\_\_

### GENERAL INFORMATION

Participant Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female  Other

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**In the event of an emergency the below information will be provided to emergency first responders:**  
Allergies - Include medication, food and others (insect stings, asthma, animal dander etc.) Describe reaction and management of the reaction.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child carry an Epi-Pen? \_\_\_\_\_

Medications: Please list ALL medication taken routinely. Keep medication in the original packaging/ bottle that identifies the prescribing physician (if prescription), the name of the medication, the dosage, and the frequency of administration.

Med: \_\_\_\_\_ Dosage \_\_\_\_\_ Times of day taken \_\_\_\_\_  
Med: \_\_\_\_\_ Dosage \_\_\_\_\_ Times of day taken \_\_\_\_\_  
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(Attach additional pages for more medications)

**INSURANCE INFORMATION**

Do you have health/accident insurance? Yes No

Company Name/Address: \_\_\_\_\_

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

George Mason University does not offer any form of health, liability or other types of insurance for the participant while participating in the Program.

**EMERGENCY CONTACT INFORMATION**

List at least two and up to four individuals who may be contacted in case of emergency involving your child. Each person listed should be reachable by telephone and able to make decisions on behalf of your child if a parent and legal guardian cannot be reached. If necessary, an emergency contact should be able to come to the Program site and pick up your child.

**Emergency Contact #1 Name:** \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Relation: \_\_\_\_\_

**Emergency Contact #2 Name:** \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Relation: \_\_\_\_\_

**Emergency Contact #3 Name:** \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Relation: \_\_\_\_\_

**Emergency Contact #4 Name:** \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Relation: \_\_\_\_\_

**AUTHORIZATION FOR MEDICAL CARE**

To the best of my knowledge, my child/participant is capable of participating safely in the Program and that any activity restrictions, allergies, and medications are listed on this form.

I give my permission to Program staff to provide routine first aid care and in the event of serious illness or injury, I give Program staff permission to seek and authorize emergency medical treatment. I agree to indemnify and hold harmless George Mason University, the Commonwealth of Virginia, and their officers, employees and agents, from any claim, damage, liability, injury, expense, or loss, including defense costs and attorney's fees, arising out of or resulting from said medical treatment. I further agree to accept full responsibility for any and all expenses, including medical expenses, that may derive from any injuries to my child that may occur during his/her participation in this Program.

I understand and acknowledge that my failure to disclose relevant information may result in harm to Participant and/or others during this Program. By signing my name, I represent that I have provided all materials and important information to the Program pertaining to Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify the Program of any changes in mental, physical or medical condition before the Program begins.

Parent/Legal Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date: \_\_\_\_\_ E-mail: \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date: \_\_\_\_\_ E-mail: \_\_\_\_\_