

Program MSU Performing Arts Camps for Drum Majors and Color Guard Performers – 2008

Dates Attending July 2008



**AUTHORIZATION FOR PURPOSES OF PROVIDING MEDICAL TREATMENT
MICHIGAN STATE UNIVERSITY**

Your son/daughter will be involved in a Michigan State University program on the above date(s). We are asking you to complete this form to give an appropriate medical facility permission to treat him/her for minor injury or medical problems. In the event of serious injury or illness, you will be contacted; treatment will proceed before contacting you only if the situation is urgent and does not permit delay.

Child's Name _____ Date of Birth _____

Address _____ Name of Primary Care Physician _____

_____ Address _____

Phone _____ Phone _____

INFORMATION NEEDED ABOUT CHILD: YES NO IF YES - INDICATE OR LIST BELOW

Is there any chronic problem or illness? _____

Has the person been treated recently for some medical problem? _____

Are there any allergies to medications or local anaesthesia? _____

List any medications now being taken for treatment of any medical problem _____

Date of last Tetanus Shot: _____

CHILD'S Social Security Number _____

HEALTH INSURANCE INFORMATION:

Policyholder's Name and Relationship to Patient _____

Policyholder's Address _____

Name and Address of Insurance Co. _____

If you have HMO or PHP insurance - list the emergency treatment authorization phone number _____

Name and Address of Employer _____

All Policy Numbers (please identify) _____

Subscriber's Social Security Number _____

I, _____, as parent/legal guardian of _____

do hereby authorize John Madden or his representative to seek any medical and/or surgical treatment necessary for treatment (Program Director's Name) necessary for the care of my child.

The above-designated Program Director is hereby authorized to incur medical costs necessary to provide medical treatment for said child, for which I shall be fully responsible. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature _____ Relationship to Child _____

Daytime/Work EMERGENCY PHONE NUMBER _____

Address _____