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.

____ Date_______________20_______ .
(Signature of Individual Providing Authorization)

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