NUHS THEATRICAL DANCE SUMMER WORKSHOP
CONSENT TO TREAT FORM
2014

Student Name: _____
First Middle Last

AUTHORIZATION FOR TREATMENT OF A MINOR

I (we) the undersigned parent(s) or legal guardian of the above-named minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis returned under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medical Practice Act or a dentist licensed under the provisions of the Dental Practice Act. It is understood that this authorization is given in advance f any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made, to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Should any responsible school representative be unable to contact the undersigned after a reasonable attempt has been made the undersigned do (does) hereby delegate to the responsible school representative the right to authorize medical or surgical care that is considered essential.

THIS FORM IS NOT REVIEWED BY SCHOOL MEDICAL PERSONNEL PRIOR TO TRIPS/ACTIVITIES
This health information will be provided to medical care personnel in case of an emergency

Birth Date: _____-_____-_____Last Tetanus or DPT: _____Today's Date: _____

List all medications the student takes: _____

_____

NOTE: If student needs to take medications during the workshop or has special health concerns, it is the parent's responsibility to contact the Dance Department prior to the workshop.

List any restrictions or other pertinent medical information, including any allergies to food or drugs:

_____

_____

Student Insurance Info:

Company: _____

Policy/Group #: _____

Insured's Name:_____

Family Doctor: _____

Emergency Contact Name and Phone #:_____

I request in the case of medical emergency, illness, or injury that the supervisor take the above named student to a doctor or medical facility to receive emergency treatment.

Signature of Parent or Guardian: _____