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 P: _____ 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 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.