Texas Christian University
Authorization for Medical Care

Student's full (legal name):_____

Day time emergency contact: _____

Relationship: _____ **Telephone:** _____

Is student currently being treated for a medical condition? _____ **Please list:**_____

_____

_____

Is student currently taking any medications: _____ **Please list:** _____

_____

_____

Does student have any food or other allergies we should be we should be aware of? Please list:

_____

_____

Is student allergic to any medications? _____ **Please list:** _____

_____

_____

Other information to assist with student emergency care: _____

_____

Height: _____ **Weight:** _____ **Age:** _____

I hereby represent that I am the parent and/or legal guardian having legal custody of the above named minor Student. I authorize Texas Christian University to seek and obtain any medical treatment for the Student in the event of an emergency when efforts to contact me are unsuccessful and/or when, in the judgment of the program director, the injury or illness appears to require immediate medical attention. I further authorize Texas Christian University to refer the Student to private care providers if special service is necessary and efforts to contact me are unsuccessful. I understand that an attempt will be made to contact me in the event that medical care is needed unless immediate medical attention is necessary and, in such event, an attempt to contact me will be made as soon as possible. I further understand and agree that I am responsible for any and all medical expense incurred as a result of bodily injury to, or illness of, the participant named while on Texas Christian University campus, including, but not limited to transportation to the other medical facilities, as well as private follow-up care.

_____

Parent/Guardian Signature (if student is under 18) Date

*****participants must provide a copy of current medical insurance card with this form**

_____

Student Signature (if over 18) Date