Medical Treatment Authorization Form

Name: ____ **DOB** __/__/__

Camp: ____

Date of Camp: ______________________________________

Participants are automatically enrolled in MSU's accident insurance plan. Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance.

Medical conditions that camp staff should be aware of: ________________________

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Current Medications: ____

Allergies: ____

In case of emergency please contact:

Name: _________________________________

Daytime Phone: _____________________________

Nighttime Phone: ____________________________

Medical Insurance Company: ____

Medical Insurance Policy Holder name _________________ **Date of Birth** ______________

Medical Insurance Phone: _____________________________________

Policy numbers: ____

□ **I, ___________________, as parent or legal guardian of the participant named above, authorizes MSU to seek medical and/or surgical treatment which is reasonably necessary to care for the participant. I further authorize the medical facility that treats the participant to release all information needed to complete insurance claims. I acknowledge my responsibility to pay all costs associated with the participant's medical care and authorize all insurance payments, if any, to be made directly to the medical facility.**

□ **I, __________________________certify that I am over the age of 18 and parent or legal guardian of participant named above and, I acknowledge that I understand and agree to the terms as outlined above.**

Parent or Guardian Signature ____