



PERMISSION FOR MEDICAL TREATMENT

Full Legal Name of Student \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

In the event of illness or accident, I hereby authorize personnel of Middle Georgia State University (MGA) to act for me in my behalf as the parent or other person having the legal authority to act for the child named above in the securing of medical treatment. In the event of an emergency, I hereby give permission to the physician, EMS, Bleckley Memorial Hospital (BMH), and/or any contract personnel at BMH to hospitalize and/or secure proper medical treatment for child named.

\_\_\_\_\_  
Parent/Guardian Signature Date

Complete Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_  
Mother's Work Phone \_\_\_\_\_ Father's Work Phone \_\_\_\_\_  
Mother's Cell Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_

If parent not available in an emergency, notify:

1. \_\_\_\_\_  
Name Phone Relationship
2. \_\_\_\_\_  
Name Phone Relationship

**Medical Information:**

Student's primary physician and phone number \_\_\_\_\_

Pharmacy used and phone number \_\_\_\_\_

**Health History:**

Please list - *(if none, please answer as none)*

(1) any known allergies of the student (drugs, insects, food, other) \_\_\_\_\_

(2) all prescription medications student will have on campus \_\_\_\_\_

(3) any chronic or recurring illnesses \_\_\_\_\_

(4) any operations or serious injuries (dates) \_\_\_\_\_

(5) Date of last Tetanus Shot \_\_\_\_\_

**Insurance:**

It is the student's responsibility to provide new insurance information if changes occur.

Name, Address & Telephone Number of Insurance Company \_\_\_\_\_

Policy/Group Number \_\_\_\_\_ Member ID Number \_\_\_\_\_

DOB of Insured \_\_\_\_\_ Place of Employment of Insured \_\_\_\_\_

Please attach copy(ies) of insurance card(s). Even though your student may have a card on his/her person, an emergency can be handled quicker if the card is already copied and available. It is the student's responsibility to provide new insurance information if changes occur.

**PAYMENT GUARANTEE, ASSIGNMENT OF INSURANCE, AND AUTHORIZATION FOR THE RELEASE OF INFORMATION**

I, the undersigned, hereby agree that I will guarantee the payment of the bill for services rendered by hospital and physicians. I hereby authorize payment directly to hospital and physicians for services rendered. I understand I am financially responsible to the hospital and physicians for charges not covered by said insurance.

Authorization is hereby granted to release to the \_\_\_\_\_  
(name of insurance company or companies)

such information as may be necessary for the completion of my hospital claims.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_