

Parental/Guardian Authorization for Treatment of Minors (under age 18)

Section 1—TREATMENT AUTHORIZATION

I authorize the provision of medical or hospital care deemed necessary for:

Name:					
	First		Middle	Last	
Date of Birth:	/	/			

In the event an illness or injury occurs during his or her volunteer service to Florida Atlantic University, I further authorize each of the following:

- I grant permission to the treating physician or other health care providers to employ such diagnostic procedures and medical treatment as deemed necessary.
- I authorize all medical care units to release medical record information to the University's workers' compensation health care provider and insurance carrier in order to process claims.

I understand that I am financially responsible for charges not covered by the University or insurance and hereby guarantee full payment to the physicians or health care units.

Section 2—PHYSICIAN/EMERGENCY CONTACT INFORMATION Family Physician

Name:	Phone:
Address:	
Emergency Contact	
Name:	Phone:
Address:	
Section 2 DADENT/CUADDIAN INFODMAT	ION

Section 3—PARENT/GUARDIAN INFORMATION

Name of Parent or Guardian:		
Phone: (Home)	(Work)	(Cell)
Address:		
Signature:		
Name of Parent or Guardian:		
Phone: (Home)	(Work)	(Cell)
Address:		
Signature:		Date:
	BY THE DEPARTMENT Depa	ertment documentation for telephone authorization
Relationship to Volunteer:		
Witnesses:		
Description:		
Date:	Time	e: