RISK MANAGEMENT
SERVICES
UNIVERSITY OF NORTH TEXAS™

Program for Minors Medical Information and Release Form

NAME OF PROGRAM: ____

NAME OF PROGRAM PARTICIPANT: ____

ADDRESS: ____

CITY: ____STATE: _________________ZIP: ______________

DATE OF BIRTH: ________________ SEX: ______________ HEIGHT: ______________ WEIGHT: ____________

PARENT (or guardian) NAME: ____

ADDRESS: ____

CITY: ____STATE: ________________ZIP: _______________

CELL PHONE: ( ) ______________________ EMERGENCY PHONE: ( ) ______________________

EMERGENCY CONTACT NAME: _____________________________________ RELATION: __________________

CELL PHONE: ( ) ______________________ EMERGENCY PHONE: ( ) _______________________

PRIMARY CARE PHYSICIAN: ________________________________ PHONE: ( ) ______________________

DO YOU HAVE HEALTH INSURANCE? YES: ________ NO: ________

___________________________	__________________________	___________________________
NAME OF CARRIER	POLICY NUMBER	Name of Primary Insured

A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD MUST BE ATTACHED.

Does the Program Participant have any chronic or acute medical problems? YES: ________ NO: ________

Please explain: ____

____

List any allergies to food, pollen, or medicine: ____

List any medications being taken at present time: ____

List any other conditions we should be aware of: ____

My child has permission to attend a Program for Minors sponsored by the University of North Texas. I fully realize that injury or illness to my child may result from or during participation in the program. In case of injury or illness, I give permission for my child to be given medical treatment as deemed appropriate. I further give permission for the information provided on this form to be shared with appropriate medical personnel. I further give permission for and grant authority to the program representatives to sign on my behalf the Notice of Privacy Practice that patients are required to receive in accordance with federal law. I understand and acknowledge that I will be responsible for any medical bills incurred by my child at the University of North Texas Student Health and Wellness Center, at a local hospital or elsewhere.

Signature: ____ **Date:** ____________________