

Sam Houston State University

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT - ADULT

I. MEDICAL INFORMATION (please type or print legibly)

a. Name \_\_\_\_\_  
(Last, first, middle)

Address \_\_\_\_\_  
(Street or P.O. Box, city, state, zip code)

Telephone Number: Day P: \_\_\_\_\_ Emergency \_\_\_\_\_

d. Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_  
(Street or P.O. Box, city, state, zip code)

Telephone Number: Office \_\_\_\_\_ Emergency \_\_\_\_\_

e. Health Insurance Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Telephone \_\_\_\_\_

f. Allergies \_\_\_\_\_

g. Current Medications \_\_\_\_\_

h. Special Health Needs \_\_\_\_\_

II. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned, do hereby authorize Sam Houston State University and its agents or representatives to consent on my behalf, to any medical/hospital care or treatment (including locations outside the U.S.) to be rendered upon the advice of any licensed physician. I agree to be responsible for any necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

The effective dates of this authorization are \_\_\_\_\_ to \_\_\_\_\_ 20\_\_\_\_ .

I am eighteen years of age or older, have read the above authorization, and confirm that the information contained therein is true and accurate.

\_\_\_\_\_  
(Signature of Individual Providing Authorization) Date \_\_\_\_\_ 20\_\_\_\_ .

To be completed by persons eighteen years of age or older.