**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, HHC, Houston County Medical Center, and/or any contract personnel at HHC 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 ________________________________________________