PERMISSION/EMERGENCY INFORMATION OF MINOR STUDENT

1. Name of minor _____ Grade_____

   Date of birth (month/day/year)_____

2. Name of parent/guardian/conservator _____

   Office telephone: _____ Home telephone:_____

   Address: _____

3. Name of other parent (or both if different from #2)_____

   Father: _____ Telephone: _____

   Mother:_____ Telephone: _____

4. Friend/relative who will probably know where to locate parent in event of temporary absence

   Name:_____ Telephone: _____

This is to certify that I authorize _____ (teacher's name), or a designated representative of Austin College to secure any and all emergency medical care and treatment for _____ for acute illness suffered or injury sustained while participating in the Austin College Student Immersion workshop. This emergency treatment may be secured at a licensed hospital, clinic or medical facility, or by a licensed physician or dentist with the following exceptions: _____

_____

_____

Check one:

☐ I do not have medical insurance

☐ I do have medical insurance with_____
Insurance company and I shall assume financial responsibility for any medical treatment of my child.
Insurance Number: _____
Other information:_____

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remain the responsibility of the parent/guardian and shall not be assumed by the teacher or the faculty or staff of Austin College. Copies of this authorization may be presented to the admissions office of a hospital clinic or to a physician or dentist. Other distribution shall be only within the limitations of the Family Educational Rights and Privacy Act.

Drugs to which the student has had allergic or adverse reactions are: _____

Other pertinent health conditions shall be listed on reverse

_____ _____
Printed name of Parent/Guardian Date

_____ _____
Signature Date