

AUTHORIZATION FOR MEDICAL TREATMENT FOR MINORS

Name of Minor (*please print*): _____

Visitor's Birth Date: _____ Date of Visit: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

EMERGENCY PHONE NUMBERS FOR PARENTS OR GUARDIANS:

Name: _____ Phone: _____

Back up Emergency Contact:

Name: _____ Phone: _____

I/We being the parent(s) or legal guardian(s) of the above named minor, do hereby appoint Clarkson University staff and/or campus safety representatives to act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor during the period of my/our absence, from:

Month _____ Day _____ Year _____ through Month _____ Day _____ Year _____.

I/We also agree to assume responsibility for any medical expenses incurred during the duration of time associated with this visit.

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required. This authorization is intended to be a limited Power of Attorney providing to the above appointees those powers set forth in General Obligations Law Section 5-1502I(2).

Name of Parent/Guardian (*please print*): _____

Signature: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____ Date: _____

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR:

Insurance Company or Government Program: _____

ID or Contract Number: _____

Name of Family Physician(s): 1. _____ Phone: _____

2. _____ Phone: _____

IDENTIFY ALLERGIES OR SPECIAL MEDICAL CONDITIONS: