

**UNIVERSITY OF TEXAS AT DALLAS  
MEDICAL INFORMATION AND RELEASE FORM FOR MINOR PARTICIPANTS**

**Name:** \_\_\_\_\_  
Last First

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone Number:** ( ) \_\_\_\_\_ **Cell Phone:** ( ) \_\_\_\_\_  
Area Code Phone Number Area Code Phone Number

**Contact Number for Parent/Guardian during activity (if different from above)**  
\_\_\_\_\_

**Social Security** \_\_\_\_\_ **Birthdate** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age:** \_\_\_\_\_

**Emergency contact information and phone numbers**

**Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_

**Relation:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Medical Information**

**Physician**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_

**Emergency Phone:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Health Insurance Co.** \_\_\_\_\_

**Group No.:** \_\_\_\_\_

**Special Health Needs:** \_\_\_\_\_

**Dentist**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_

**Emergency Phone:** \_\_\_\_\_

**Medication(s) and Dosage(s)** \_\_\_\_\_

**Telephone** ( ) \_\_\_\_\_

**ID. Number:** \_\_\_\_\_

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**EMERGENCY MEDICAL AUTHORIZATION**

I, the undersigned parent or legal guardian of \_\_\_\_\_, do hereby give my permission for him to participate in Scouting University. I authorize the University of Texas at Dallas and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment to be rendered to \_\_\_\_\_ upon the advice of a licensed physician.

I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization. The effective date is March 28, 2009.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent or Guardian

**Form must be completed and signed in order to allow  
Participant to participate in Activity and/or Travel**