

**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: _____

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 22, 2008.

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**