



MEDICAL RELEASE FORM

In case of emergency, where there is not time, or it is impossible to obtain authorization by contacting a parent, guardian or spouse (must be signed by self if 18 or older or parent, guardian, or spouse) I, the undersigned, do hereby authorize to the Sports Medicine Staff and/or Coaching Staff of the University of Sioux Falls, to secure any and all emergency treatment for;

Name: _____

I further authorize any hospital or dispensary, any attending physicians and/or medical personnel to render any and all emergency medical care which may be deemed necessary.

Signature (parent, legal guardian, self) _____

State of _____ County of _____

Social Security No. _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize any physician, hospital, clinic or other medical facility to release any information to insurance carriers concerning my examination and/or treatment. I hereby assign to the physician(s), hospital, clinic, or other medical facility all payments for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

Student _____ (signature) Parent _____ (signature also required if insurance coverage is through parent's policy)

STUDENT HEALTH RECORD - UNIVERSITY OF SIOUX FALLS

Name _____ last first middle Allergies: _____

Home Address _____ street Medications: _____

_____ city state zip home phone no.

Sports Participating in _____ Last Tetanus: _____

Parent, Guardian or Spouse _____ Today's Date _____

Address _____ street Yr. In College _____

_____ city state zip home phone no. Sex: F _____ M _____

Birth Date _____

Parent, Guardian or Spouses' Employer _____

_____ address business phone no.

*Insurance Company _____ Please sign insurance authorization

Group _____

Policy # _____ Cert. # _____

Authorization or Pre-Certification Phone # _____