Authorization for Emergency Treatment
Allied Health Department | Mineral Area College

Student Information

Name: _____ MAC Student ID: _____

Allergies: ❑ Nuts/Seeds ❑ Eggs/Dairy ❑ Fish/Shellfish ❑ Gluten ❑ Latex ❑ Other: _____

Current Prescription Medication: _____

Special Needs: _____

Emergency Contact Person

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Email: _____ Cell: _____

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Email: _____ Cell: _____

Emergency Medical Authorization Information

Insurance Company: _____ Subscriber's Name: _____

Policy Number: _____ Group Number: _____

_____

Family Physician Name Address Phone

_____

Dentist Name Address Phone

_____

Preferred Hospital Address Phone

In the event that reasonable attempts to obtain my consent have been unsuccessful I, the undersigned, do hereby authorize Mineral Area College and its designated representatives to consent, on my behalf, to any medical care to be rendered upon the advice of a licensed physician. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. I agree to be responsible for all necessary charges incurred by any care, treatment or hospitalization rendered pursuant to this authorization. I am 18 years of age or older, and I agree to these terms.

_____ _____ _____

Student Signature MAC Student ID Date

_____ _____ _____

Witness Signature Title Date