ST. EDWARD'S UNIVERSITY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

PERSONAL INFORMATION

Name (First, Middle, Last):	SEU ID#:

Address:

_____

_____

Phone: ( )	Alternative Number: ( )

Allergies:

Current Medications:

Special Health Needs or Conditions:

EMERGENCY CONTACT INFORMATION

Primary Contact Name:	Relationship:

Phone: ( )	Alternative Number: ( )

Secondary Contact Name:	Relationship:

Phone: ( )	Alternative Number: ( )

PHYSICIAN INFORMATION

Physician's Name:

Address:

_____

_____

Phone: ( )	After Hours/Emergency Phone: ( )

INSURANCE INFORMATION

Health Insurance Company Name:	Name of Policy Holder:

Policy Number:	Group Number:	Phone: ( )

EMERGENCY MEDICAL AUTHORIZATION

I authorize St. Edward's University and its agents or representatives to consent on my behalf to any medical or hospital care or treatment (including treatment in locations outside of the United States) to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

Printed Name:	Signature:	Date:

Printed Name of Parent/Guardian (if above person is a minor) :	Signature:

The effective dates of this authorization are as follows:

_____ TO _____ 20_____ Initial that you agree to these dates _____