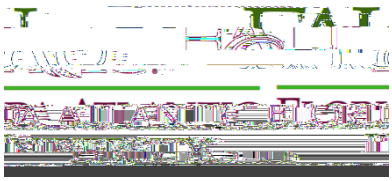

Parental/Guardian Authorization for Treatment of Minors (under age 18)

Section 1 TREATMENT AUTHORIZATION

I authorize the provision of medical or hospital care deemed necessary for:

Name: _____ Male Female
First Middle Last

Date of Birth: / /

In the event an illness or injury occurs during his or her volunteer service to Florida Atlantic University, I further authorize each of the following:

I grant permission to the treating physician or other health care providers to employ such diagnostic procedures and medical treatment as deemed necessary.

I authorize all medical care units to release medical record information to the University's workers' compensation health care provider and insurance carrier in order to process claims.

I understand that I am financially responsible for charges not covered by the University or insurance and hereby guarantee full payment to the physicians or health care units.

Section 2 PHYSICIAN/EMERGENCY CONTACT INFORMATION

Family Physician

Name: _____ Phone: _____

Address: _____

Emergency Contact

Name: _____ Phone: _____

Address: _____

Section 3 PARENT/GUARDIAN INFORMATION

Name of Parent or Guardian: _____

Phone: (Home) _____ (Work) _____ (Cell) _____