Consent for Medical Treatment for minors

Dates Attending High School Journalism Institute:

July 10-14 AND/OR July 16-20

(circle the correct date)

I,_____, am the parent or legal guardian of _____

and I authorize (name of program)_____to obtain emergency medical treatment of this minor by an appropriate health care professional should the need arise while he/she is attending the program.

Signature_____Date _____

Medical Information (all participants)

Participant's name _____ Age _____

Birthdate_____Date of last Tetanus shot _____ Past health/injuries_____

_____Present health _____

_____ Allergic reactions _____

_____ Present medication _____

____ Check here if the participant has special needs and might require accommodations to fully participate in the program. A staff member will contact the parent or guardian for details.

Other information that would be useful in the event medical treatment is necessary: _____

Insurance Information (all participants)

Parents or legal guardians are responsible for the cost of a minor's medical treatment. When available, insurance information will be processed by the health facility performing the treatment, otherwise you will be contacted for payment by cash, check or credit card.

Insurance company_____Address_____

City/State/Zip_____

Policyholder's name _____

Policy number _____

Contact People (all participants)

In an emergency, parents or legal guardians can be reached as follows:

Name_____Relationship to minor _____
Address_____Daytime phone _____
City/State/Zip_____Evening phone _____
Cell phone _____

Name_____Relationship to minor _____
Address_____Daytime phone _____
City/State/Zip_____Evening phone _____
Cell phone _____

If other information would be helpful in contacting you, please indicate:

_____

Please return by July 1 to: Linda Johnson, High School Journalism Institute, Indiana University, Franklin Hall 230, 601 E. Kirkwood Ave., Bloomington, IN 47405. You may also scan and email the form to: Linda (LJJOHNSO@INDIANA.EDU).