**NMSU Sponsored Youth Program**

**MEDICAL INFORMATION AND**

**TREATMENT AUTHORIZATION**

No Participant may attend any programs, events, camps or retreats for minors, sponsored by New Mexico State University (NMSU), prior to the completion of this form by a custodial parent or a legal guardian. Additional pages may be attached if needed.

**Participant Information:**

|  |  |
| --- | --- |
| Participant Name: |  |
| Name of Custodial Parent(s) or Legal Guardian: |  |
| Physical Home Address:  |  |
| Local Address (if different): |  |
| Participant Phone No.: |  |
| Age: |  | Birth Date: |  |

**Emergency Contact Information:**

|  |  |
| --- | --- |
| Emergency Contact Name: |  |
| Phone Numbers:  |  |
| Alternate Emergency Contact: |  |
| Phone Numbers: |  |

**Personal Physician (Primary Care) Information:**

|  |  |
| --- | --- |
| Physician Name: |  |
| Phone Numbers:  |  |

**Health Insurance:**

|  |  |
| --- | --- |
| Insurance Company Name: |  |
| Name of Policy Holder:  |  |
| Identification No.: |  |

**Participant’s Immunizations:**

|  |  |
| --- | --- |
| List immunizations which are not current: |  |
| Date of most recent Tetanus vaccination:  |  |

**Participant Medical Background**

|  |  |
| --- | --- |
| Special services required due to physical or medical condition:  |  |
| Restrictions on physical activities:  |  |
| Medications (prescription and over the counter) currently taken, including dosage and frequency: |  |
| Describe any assistance needed with medication management: |  |
| Vision – does Participant utilize glasses or contact lenses? |  |
| Dietary Restrictions: |  |
| Allergies (medications, foods, insects, plants): |  |
| Medical History – mark any that apply to participant. | Heart Disease \_\_\_Yes Epilepsy \_\_\_Yes Diabetes \_\_\_Yes  | Asthma \_\_\_Yes High Blood Pressure \_\_\_Yes |
| Other medical information of which NMSU should be aware: |  |

By signing below, I represent that I am a custodial parent or legal guardian of the Participant indicated above, who is under the age of 18, and that the information provided above is accurate. My signature also represents my permission for treatment by a licensed physician (if medical treatment is deemed necessary by the physician) and my acceptance of complete financial responsibility for all medical services rendered to the Participant.

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Parent or Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent or Legal Guardian