The University of Texas at Austin

authorization for emergency medical treatment- adult

**I. MEDICAL INFORMATION** (please type or print legibly)

a. Name

(last, first, middle)

Address

(street or P.O. box, city, state, zip code)

Telephone Number: Day ( ) Night ( )

b. Name of Nearest Relative

(last, first, middle)

Address

(street or P.O. box, city, state, zip code)

Telephone Number: Day ( ) Night ( )

c. Physician’s Name

Address

(street or P.O. box, city, state, zip code)

Telephone Number: Office ( ) Emergency ( )

d. Dentist’s Name

Address

(street or P.O. box, city, state, zip code)

Telephone Number: Office ( ) Emergency ( )

e. Health Insurance Company Name

Policy Number Telephone ( )

f. Allergies

g. Current Medications

h. Special Health Needs

**II. EMERGENCY MEDICAL AUTHORIZATION**

I, the undersigned, do hereby authorize The University of Texas at Austin and its agents or representatives to consent, on my behalf, to any medical/hospital care or treatment (including locations outside the U.S.) 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.

The effective dates of this authorization are **\_\_\_\_\_\_\_\_\_\_­­\_\_** to **\_\_\_\_\_\_\_\_\_\_­­\_\_**

I am eighteen years of age or older, have read the above authorization, and confirm that the information contained therein is true and accurate.

Date 200 .

Signature of Individual Providing Authorization)

(for persons eighteen years of age or older) revised 3-97