I, ________________________________, BEING THE PARENT OR LEGAL GUARDIAN OF ________________________________ GRANT THE FOLLOWING AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT OF THIS MINOR BY A HEALTH CARE PROFESSIONAL SHOULD THE NEED ARISE WHILE HE/SHE IS ATTENDING THE IU EARTHQUAKE SCIENCE SYMPOSIUM FOR THE TIME PERIOD STARTING ____3/27/04______ AND ENDING ____3/28/04______.

PLEASE COMPLETE ONE OF THE FOLLOWING:

1. I GRANT PERMISSION TO THE DIRECTORS, ASSISTANTS, OR OTHER PERSONS RESPONSIBLE FOR HIS/HER CARE TO ACT ON MY BEHALF FOR SAID MINOR IN GRANTING PERMISSION FOR EVALUATION AND TREATMENT OF MEDICAL OR PSYCHOLOGICAL PROBLEMS. I UNDERSTAND THAT SHOULD A MAJOR MEDICAL OR PSYCHOLOGICAL PROBLEM ARISE, REASONABLE ATTEMPTS WILL BE MADE TO NOTIFY ME BY TELEPHONE. IN THE EVENT THAT I CANNOT BE REACHED, I GIVE MY CONSENT TO SUCH MEDICAL TREATMENT AS DEEMED NECESSARY, INCLUDING SURGERY, X-RAY EXAMINATIONS, AND ANESTHESIA TO BE RENDERED TO SAID MINOR BY A LICENSED PHYSICIAN OR NURSE.

   DATE ___________________ SIGNATURE ________________________________

2. I DO NOT WISH MEDICAL CARE OF ANY KIND, EXCEPT IN CASE OF AN EMERGENCY.

   DATE ___________________ SIGNATURE ________________________________

3. I AUTHORIZE LIMITED MEDICAL CARE AS FOLLOWS ________________________________

   ________________________________

   ________________________________

   ________________________________

   DATE ___________________ SIGNATURE ________________________________
MEDICAL INFORMATION (Please print)

PARTICIPANT’S NAME ________________________ SOCIAL SECURITY NUMBER ______________________
AGE ___________ BIRTH DATE ___________ DATE OF LAST TETANUS TOXOID ______________________
PAST HEALTH / INJURIES ________________________________________________________________
PRESENT HEALTH _______________________________________________________________
ALLERGIC REACTIONS _______________________________________________________________
PRESENT MEDICATION ______________________________________________________________
Other information that would be useful in the event medical treatment is necessary:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

CONTACT INFORMATION (Please print)

IN AN EMERGENCY, PARENTS OR LEGAL GUARDIANS CAN BE REACHED AS FOLLOWS:
NAME ________________________ RELATIONSHIP TO MINOR ________________________
ADDRESS ________________________ DAYTIME PHONE ________________________
CITY/STATE/ZIP ________________________ EVENING PHONE ________________________
_________________________________________________________________________________
IN AN EMERGENCY, PARENTS OR LEGAL GUARDIANS CAN BE REACHED AS FOLLOWS:
NAME ________________________ RELATIONSHIP TO MINOR ________________________
ADDRESS ________________________ DAYTIME PHONE ________________________
CITY/STATE/ZIP ________________________ EVENING PHONE ________________________
_________________________________________________________________________________
IN AN EMERGENCY, PARENTS OR LEGAL GUARDIANS CAN BE REACHED AS FOLLOWS:
NAME ________________________ RELATIONSHIP TO MINOR ________________________
ADDRESS ________________________ DAYTIME PHONE ________________________
CITY/STATE/ZIP ________________________ EVENING PHONE ________________________

INSURANCE INFORMATION (Please print)

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 ________________________ RELATIONSHIP TO MINOR ________________________
POLICY HOLDER’S NAME ________________________ POLICY NUMBER ________________________