HEALTHFORM

This form must be filled out and signed to complete your registration. Return by **mail** to: MIPA, 404 Wilson Road Room 305, East Lansing, MI 48824; **fax** to 517-355-7710 or **email** to mipa@msu.edu.

MEDICAL TREATMENT AUTHORIZATION

Your child will be involved in the Michigan Interscholastic Press Association Summer Journalism Workshop at Michigan State University from July 30–Aug. 3, 2017. This form must be completed and signed by a parent or guardian to give a medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated only if the situation is urgent and does not permit delay.

Participant's full legal name:

Last First M.I.

Mailing Address:

Birth date (MM/DD/YYYY): / /

Emergency contact name:

Emergency contact phone: day ( )

evening ( ) cell ( )

Primary care physician's name:

Physician's phone: ( )

Physician's address:

HEALTH INSURANCE INFORMATION

Policyholder's name/relationship to patient:

Policyholder's address:

Please attach a photocopy of both sides of your insurance card OR complete the following:

Insurance company name/address:

Insurance company phone number: **( )**

All policy #s (please identify):

If you have HMO insurance, list emergency treatment authorization phone number:

( )

Name and address of policyholder's employer:

Business phone: **( )**

INFORMATION NEEDED ABOUT PARTICIPANT

Please circle yes or no. If yes, explain below or on another sheet.

Please specify special needs, i.e. diet, handicapper accessibility, etc.:

Does the participant have any chronic problem or illness?	NO	YES
Does the participant have any acute illness now?	NO	YES
Has the participant been treated recently for a medical problem?	NO	YES
Does the participant have any allergies?	NO	YES
Any allergies to medication or local anesthetics?	NO	YES

Date of participant's last tetanus shot:

List any medications being taken for treatment of a medical problem:

I (parent or legal guardian), _____, recognize that while attending this program, medical treatment on an emergency basis may be necessary for my child, and I further recognize that the program directxor may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the circumstances and to assume the expenses of such care. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature of Parent/Guardian or of participant aged 18 and up Date