

EMERGENCY HEALTH— Nittany Lion 7 vs. 7 Field Hockey Invitational

[] Field Hockey Invitational, May 23, 2009

Last name First name Middle initial

Penn State ID no.* Age

Home phone no. Home address (no. and street, or box no.)

City State ZIP code

Parent's/guardian's daytime phone no. _____ Home phone no. _____

Cell phone no. (if applicable) _____

MEDICAL TREATMENT AND INSURANCE AUTHORIZATION

I hereby authorize the clinical staff of University Health Services, Penn State Hershey–State College Orthopaedics, and Mount Nittany Medical Center to provide care that includes routine diagnostic procedures (e.g., x-rays, blood and urine tests) and medical treatment as necessary to my minor son/daughter,

I understand that the consent and authorization herein granted do not include major surgical procedures and are valid only during the camp. Physical conditions that the clinician should be aware of (allergies, recurring illnesses, disabilities, chronic illnesses, etc.):

Date of most recent tetanus immunization: _____
(If more than ten years ago, a booster shot is recommended.)

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency, and if I cannot be reached, I give my consent for physicians and staff at University Health Services, Penn State Hershey–State College Orthopaedics, and the Emergency/Outpatient Department of Mount Nittany Medical Center to perform any necessary emergency treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.

HIPAA

Penn State honors the privacy of the participants in its programs and complies with the national regulations regarding health information. For a summary of the national standard, see http://www.hhs.gov/ocr/hipaa/consumer_summary.pdf.

I authorize The Pennsylvania State University to receive medical/billing information and submit it to our insurance carrier.

Name of emergency contact Phone no.

Name of family physician Phone no.

Parent's/guardian's name (please print) Signature

Insurance company Insurance company address (no. and street, or box no.)

City State ZIP code

Policy subscriber's name Policy no. Group no.