Return 1 week prior to travel to:

Office of Vice President for Student Services
Kim Byrd, GW412
307-268-2210

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT – ADULT

II. MEDICAL INFORMATION (Please type or print legibly)

Name _____
(Last, First, Middle)

Emergency contact 1 _____
(Last, First)

Address _____
(Street, City, State, Zip Code)

Telephone Number: Day (____) _____ Night (____) _____

Emergency contact 2 _____
(Last, First)

Address _____
(Street, City, State, Zip Code)

Telephone Number: Day (____) _____ Night (____) _____

Physician Name _____

Address _____
(Street, City, State, Zip Code)

Telephone Number: Office (___) _____ Emergency (____) _____

Health Insurance Company Name _____

Policy Number _____ Telephone (____) _____

Allergies _____

Current Medications _____

Special Health Needs _____

II. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned, in the event no other mechanism is in place designating some other individual to make healthcare treatment decisions for me, and/or emergent circumstances do not provide sufficient time for the mechanism to be implemented, do hereby authorize Casper College 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.

Effective dates of authorization are _____ To _____

_____ Date _____
(Signature of Individual Providing Authorization)