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 – MINOR

I. MEDICAL INFORMATION (Please type or print legibly)

Name of Minor _____
(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 (____) _____

Minor's Physician _____

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

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

Health Insurance Company Name _____

Policy Number _____ Telephone (____) _____

Minor's Allergies _____

Minor's Current Medications _____

Minor's Special Health Needs _____

II. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent /legal guardian of _____ (Name of minor)

in the event no other mechanism is in place designating some other individual to make healthcare treatment decisions, and/or emergent circumstances do not provide sufficient time for the mechanism to be implemented for my dependent child, 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 to him or her 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 _____ 20 _____.

_____ Date _____ 20 _____.
(Signature of Parent or Guardian)