THE UNIVERSITY OF TEXAS AT EL PASO
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT- MINOR

I. MEDICAL INFORMATION (please type or print legibly)

a. Name of Minor _____
(last, first, middle)

b. Name of Parent/Guardian _____
(last, first, middle)

Address _____
(street or P.O. box, city, state, zip code)

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

c. Minor's Physician _____

Address _____
(street or P.O. box, city, state, zip code)

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

d. Minor's Dentist _____

Address _____
(street or P.O. box, city, state, zip code)

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

e. Health Insurance Company Name _____

Policy Number _____ Telephone (____) _____

f. Minor's Allergies _____

g. Minor's Current Medications _____

h. Minor's Special Health Needs _____

II. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent or legal guardian of _____,
(name of minor)

do hereby authorize The University of Texas at El Paso 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)