

Texas State University
Authorization for Medical Treatment For Minors

I, _____, the _____ of _____,
(name of parent/legal guardian) (relation to child) (printed name of child)

give the Minor named above permission to use transportation provided by Texas State University and to participate in this Texas State University hosted/sponsored activity. The Minor has my permission to participate in all activities related to this event.

I also give permission to an authorized Texas State University representative to furnish such medical care as the Minor named above may require. Emergency treatment, i.e., treatment in the event of serious illness/injury or the need for hospitalization and/or major surgery, is also granted. The Texas State representative will use all reasonable efforts to contact the emergency reference names herein. Failure of such efforts, however, should not prevent the representative from providing such medical and/or emergency treatment as may be necessary for the best interest of the life of the Minor named above. I further understand and agree that Texas State University is not liable, financially or otherwise, for any costs incurred as a result of such medical and/or emergency treatment provided to the Minor named above.

In consideration for providing or securing medical care or treatment to the above-named Minor, I, individually and as the parent/guardian of the above-named Minor, release, discharge, and agree not to sue any of the Releasees for any claims, demands, actions, and causes of action of any nature whatsoever including without any limitation any claims of negligence, arising out of the medical care or treatment provided or secured for the above-named Minor.

THE RELEASE, DISCHARGE, AND COVENANT NOT TO SUE SET FORTH HEREIN IS SPECIFICALLY INTENDED TO INCLUDE CLAIMS CAUSED, OR ALLEGED TO HAVE BEEN CAUSED, IN WHOLE OR IN PART, BY THE RELEASEES' OWN NEGLIGENCE in providing or securing medical care or treatment to the above-named Minor.

Please complete the section below.

Name of Insurance Company: _____ Policy # _____

Name of Family Physician: _____ Phone # _____

In case of emergency, contact _____

Work # _____ Home # _____ Relation to child _____

Second Contact _____

Work # _____ Home # _____ Relation to child _____

Printed Name (Parent or Legal Guardian)

Date _____

Signature (Parent or Legal Guardian)