Club Medical Release & Emergency Contact Form

Health Record & Authority to Render Medical Services

The following information is required for your health file. The information is strictly confidential and accessible only to the club Advisor, Student Services Staff and Mott Community College Officials. Please complete each item fully and accurately, and be sure to complete the reverse side. The form must be signed.

Students Name _____
Last First Middle

Address _____
Number & Street (include apt. #) City/State/Zip

Home Phone _____ Cell Phone _____

Email _____

Who to contact in case of emergency?

Name_____Relationship _____

Address (if different) _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

What, if any, medications do you take regularly? _____

What was the date of your last Tetanus Booster? _____

If you are or have been under a physician's care recently for anything other than a minor illness, please describe (i.e. Epilepsy, Diabetes, etc)

_____

_____

_____

Authorization for Medical Treatment

I hereby grant permission to the_____Club Advisor or Trip Chaperone of Mott Community College in Flint, Michigan to furnish minor medical care which the above named student might require. Further permission for the emergency treatment, i.e. treatment in the event of serious illness or the need for hospitalization or surgery, is granted upon understanding that the Club Advisor or Trip Chaperone have used all reasonable efforts to contact the emergency contact person named herein. Failure in such efforts, however, should not prevent the Club Advisor or Trip Chaperone or authorized representative from pursuing emergency treatment under the care of a licensed physician and necessary for the best interest of the life of the above named student. I further understand that Mott Community College, the club, Club Advisor, Trip Chaperone or authorized representative of Student Services, are not legally liable, financially or otherwise for such emergency treatment.

Student Signature_____Date _____

Name of Insurance Company_____

Insurance Policy & Group Numbers _____

Name of Primary Cardholder _____

Name of Family Physician _____

Phone _____

Address _____

_____

Advisor Signature