

**Northeastern State University
Authorization for Emergency Medical Treatment – Adult**

Medical Information (Please type or print legibly)

A. Name _____

Address _____

Telephone Number Day _____ Night _____

B. Physician's Name _____

Address _____

Telephone Number Day _____ Night _____

C. Name of Nearest Relative _____

D. Address _____

Telephone Number Day _____ Night _____

E. Dentist's Name _____

Address _____

Telephone Number Day _____ Night _____

F. Health Insurance Company Name _____

Policy Number _____ Telephone _____

G. Allergies _____

H. Current Medications _____

I. Special Needs _____

Emergency Medical Authorization

I, the undersigned, do hereby authorize Northeastern State University 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.

The effective dates of this authorization are _____ to _____

I am eighteen years of age or older, have read the above authorization, and confirm that the information contained therein is true and accurate.

Signature of Individual Providing Authorization

Date