**Medical Information and Medical Consent**

**Student’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I/We attest that there is no health-related reason for my child not to participate in [program] and any related activities. I/We authorize WMU and/or its designee(s), to release medical information regarding my child to those who have a legitimate need to know including program instructors, staff, and/or medical providers.

I/we acknowledge that WMU will not administer or monitor any on-going medication, medical treatment, or procedure that my child may need, including, but not limited to, inhalers, epi-pens, or insulin. My child is solely responsible for administering or monitoring treatment/medications for any chronic health condition disclosed below.

Please list any personal or family medical history that may be of importance to our records, including allergies and physician prescribed medicine that student is currently taking:

|  |  |
| --- | --- |
| List Medication/Health Condition/Relevant Health History | List any allergies and the reaction that might occur |
|  |  |
|  |  |
|  |  |
|  |  |

As the parent/guardian of the above named student, I hereby authorize the [Program] Director and/or his/her designee(s) to diagnose or treat my child as may be considered necessary or appropriate under the circumstances.

Western Michigan University and its officers, regents and employees shall not be liable in any way for any consequences from said diagnosis or medical treatment, and are hereby released from any and all claims and causes of action that may arise out of such actions to the fullest extent allowed by law or the student’s group medical insurance plan.

Is the student covered by medical insurance? \_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_No

Name and Phone number of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that in the event WMU must provide or obtain medical care or treatment for my child, I will be required to present evidence of insurance to the medical provider. The University does not assume any financial or other responsibility for medical services provided.

**In case of sudden illness or accident, I consent to emergency treatment by professional medical/nursing staff. In case of serious illness/accident I will be notified immediately. If I cannot be reached, I consent to necessary interim emergency care provided by the professional medical/nursing staff or their designee(s).**

**Parent/Legal Guardian’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Person to contact in case of Emergency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number to call in case of emergency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**