

THE UNIVERSITY OF TEXAS AT DALLAS
MEDICAL INFORMATION AND RELEASE FORM — ADULT

(Please Print Clearly)

Name First Last
Address
City State Zip
Telephone Number () Area Code Birthdate / /

Emergency contact persons and phone numbers:

Name Relation Telephone Number-day Telephone Number-night

Medical Information:

Physician Information

Dentist Information

Name Address Telephone Number-office Telephone-emergency

Allergies

Health Insurance Comp Telephone ()

Group # Policy # I.D. #

Medication(s) you are taking (including dosage)

Date of last Tetanus/Diphtheria Inoculations Blood type

Special Health Needs or Concerns

EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned, do hereby authorize The University of Texas at Dallas and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment 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 for this authorization are through

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

Date: (Signature of Participant)*

Privacy Statement: With few exceptions, you are entitled on your request to be informed about the information U.T. Dallas collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have U.T. Dallas correct information about you that is held by us and that is incorrect.

Original: Custodian Copy: Faculty or Staff member traveling with the group.

*SIGNATURE REQUIRED ON COMPLETED FORM FOR PARTICIPATION IN THE ABOVE-REFERENCED ACTIVITY AND/OR TRAVEL