

University of Oklahoma Health Sciences Center

*** Medical Information Form ***

In the event of an emergency, I permit the University to share the following information with emergency response personnel.

Name: _____ Social Security Number: _____

Date of Birth: _____

Name of Insurance Policy Holder (Primary Insured): _____

Health Insurance: _____ Insurance Phone: _____

Chronic Illness: _____

Treating Physician: _____

Date of Last Tetanus Shot: _____

Allergies: _____

Medications: (include dose and frequency): _____

Other pertinent info: _____

MEDICAL TREATMENT AUTHORIZATION

_____(Initial) I authorize the University of Oklahoma to act on my behalf in any medical emergency.

Emergency Contact (Parent or Legal Guardian required if participant is under 18):

Name _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Cell Phone _____

Additional Emergency Contact or if parent or guardian cannot be reached:

Name _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Cell Phone _____

This Sheet Should Accompany Student on Any Trip