

MEDICAL TREATMENT AUTHORIZATION FORM

Participant's Name _____

Fall Pitching/Hitting Clinics, 2011

Participants are automatically enrolled in MSU's camp insurance plan. Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance.

1. List any medical conditions that camp personnel should be aware of (use additional pages if necessary):

2. List any medications currently taking:

In case of emergency please contact:

Name _____

Daytime Telephone _____

Evening Telephone _____

Name of Medical Insurance Co. _____

Telephone _____

Insurance Policy Numbers _____

_____, as parent or legal guardian of the participant named above, I do hereby authorize the director of the clinic and her subordinates, to seek any medical and/or surgical treatment which is reasonably thought to be necessary for the care of my child. The program director is authorized to provide medical treatment for my child, and I shall be fully responsible for honoring such costs. I also authorize the medical facility to release all information needed to complete insurance claims. I authorize insurance payment directly to the medical facility.

Signature (Parent or Guardian) _____

Date _____

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