UT Health San Antonio

Medical Treatment Authorization

My child, (Please Print) _____, has the permission of the undersigned to participate in activities of the _____ (Name of Program/Activity) at the University of Texas Health Science Center at San Antonio (UTHSCSA) from _____(begin date) to _____(end date). I further authorize the principal investigator, co-directors and staff of the above mentioned program to obtain emergency medical attention on my behalf for the above named minor if in their judgment medical attention is deemed necessary. It is further agreed that UTHSCSA, the Office of the Vice President for Research, and the Office of Recruitment and Science Outreach, its employees, and agents are hereby released from any liability for any damages or injuries which my child might sustain resulting from the above activities.

Student's Name _____ High School _____

Parent/Guardian Name_____

Parent/Guardian Address_____

Parent/Guardian Phone Number _____

Parent's E-mail Address _____ Student's E-mail Address _____

Name Emergency Contact_____

Emergency Contact Phone Number_____

Please check all that apply to your child's health status.

Diabetes: ☐ YES ☐ NO Heart Condition: ☐ YES ☐ NO

Epilepsy: ☐ YES ☐ NO Asthma: ☐ YES ☐ NO

OTHER (Please explain): _____

KNOWN ALLERGIES:

Food: _____

Medication: _____

Does your child have a preference for **vegetarian** meals? (please check one) ☐ YES ☐ NO

PRINTED NAME of Parent/Legal Guardian: _____

SIGNATURE of Parent/Legal Guardian: _____

Today's Date: _____