

**Fort Hays State University
Emergency Information and Consent Form**

Name: _____

Grade: _____ Email Address: _____

Street Address: _____ City: _____ Zip: _____

Allergies or Chronic Illnesses: _____

Current Medications: _____

Are you limited in any physical activity? _____ If yes, please explain. _____

If there are any other concerns you would like to bring to our attention, please write them on the back of this sheet.

In case of accident, illness or emergency, it is necessary for Fort Hays State University to know your preference for the care of your child. Please list three (3) choices.

Parent: _____ Daytime Phone: (_____) _____ Evening Phone: (_____) _____

Parent: _____ Daytime Phone: (_____) _____ Evening Phone: (_____) _____

Relative,
Neighbor

or Friend: _____ Daytime Phone: (_____) _____ Evening Phone: (_____) _____

If parent or guardian cannot be contacted, we the undersigned parents of the child identified above hereby authorize officials of Fort Hays State University to contact directly the following physicians of our selection, and we hereby certify that we are the parents of the said minor child, and do authorize the physicians named below to render such treatment as said physicians or either of them may deem reasonably necessary, in an emergency, for the health of said child, without further authorization than here expressed. In the event neither of the physicians here named can be contacted, or either of us is unavailable to give our express consent at such time with reference to any other physician, we hereby authorize the officials of Fort Hays State University to contact any licensed physician, and we hereby authorize said physicians to render such treatment as deemed reasonably necessary, in what may be considered to be an emergency, for the health of our aforesaid minor child. *

(1st choice) Physician: _____ Phone: (_____) _____

(2nd choice) Physician: _____ Phone: (_____) _____

Hospital Preference: _____ Phone: (_____) _____

Dentist: _____ Phone: (_____) _____

Date: _____ Signature of Parent or Guardian: _____

Print name of Parent or Guardian: _____

*Expense incurred as a result of emergency ambulance use or treatment by physician will not be borne by the university or university personnel.