

Extended and/or International Field Trip

Course:

Instructor:

Destination:

Quarter:

Date Leaving:

Date Returning:

MEDICAL INFORMATION AND AUTHORIZATION FORM

Name:

Birth Date:

Age* :

Gender:

Social Security Number:

Emergency Contact:

Home Phone:

Work Phone:

Doctor's Name:

Doctor's Phone:

Insurance Company:

Policy #:

Allergies/Medical Conditions:

Authorization for Consent to Medical Treatment

I confirm that I am covered by health insurance that is equivalent to that which is offered by the California State University Health Insurance Program titled "Domestic Student Health Plan".

I state that I am in good health and know of no conditions contrary to active participation in this program.

I hereby authorize the program director to consent to any diagnostic procedure (including x-rays), to the administration of any medical or surgical treatment, or to any hospital care when any, or all are rendered under the general supervision of any licensed physician and/or surgeon.

I agree that the University is not responsible for any medical, dental or other expenses resulting from the exercise of this authorization. This authorization is given in advance of any specific diagnosis, treatment or medical care being required, and pursuant to the intent and provisions of Section 6910 of the California Family Code.

Participant Signature*:

Date:

***If student is not yet 18 years old, a Parent or Guardian must also sign attesting to the above on behalf of the participant:**

Parent/Guardian Signature*:

Date:

Printed Name:

Phone:

Address: