MEDICAL INFORMATION AND RELEASE FORM – ADULT

Name: _____
Address: _____
Phone: _____
Date of Birth: _____ **Gender:** _____

Description of Activity or Trip: _____
Location: _____ **Date(s):** _____

EMERGENCY CONTACT

Name: _____
Phone: _____

MEDICAL INFORMATION

Physician Name: _____
Phone: _____

Dentist Name: _____
Phone: _____

Health Insurance Carrier: _____
Group #: _____ **Policy #:** _____

Current Medications (if none, put n/a): _____
Allergies (if none, put n/a): _____
Date of Last Tetanus/Diphtheria: _____ **Blood Type:** _____
Special Health Needs or Concerns: _____

EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned, do hereby authorize The University of Texas at Dallas and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered to this authorization. This authorization is effective through the dates listed above. I am eighteen years of age or older, have read the above authorization, and confirm that the information contained therein is true and accurate.

Signature: _____ Date: _____

Privacy Statement: With few exceptions, you are entitled on your request to be informed about the information UTD collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have UTD correct information about you that is held by us and that is incorrect.

Rev: March 2021