UNIVERSITY OF NOTRE DAME

# INFORMATION AND CONSENT FOR EMERGENCY

# MEDICAL OR MENTAL HEALTH TREATMENT FORM FOR MINORS

Program Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Student or Minor Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission for Treatment: The information provided on this form is correct to the best of my knowledge. By my signature below, I hereby grant permission and authorize the provision of emergency medical or mental health treatment for minors/students who require care or become ill or injured while participating in a University of Notre Dame du Lac sponsored Program.

Release of Information: By my signature below, I authorize the University of Notre Dame to release medical or mental health information regarding the above named minor/student to any person or entity to whom the University of Notre Dame refers the minor/student for medical or mental health treatment.

#### TO GRANT CONSENT

### I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

### (Name of Parent/Legal Guardian) (City) (County)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby state that I am the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor.

(State) (Name of Child)

Should an emergency arise while my child is under the supervision of the staff of The University of Notre Dame du Lac, I hereby authorize the staff to obtain medical or mental health attention for my child. I hereby give consent to any necessary medical or mental health examination, anesthetic, diagnosis, surgery or treatment, blood transfusion and/or hospital or clinical care to be rendered to the above-named minor under the general or special supervision and on the advice of any therapist, psychiatrist, physician or surgeon licensed to practice medicine or provide mental health care during the Program period. All such treatment shall be at my expense, and I agree to reimburse the University or its representatives for any expenses that they or any of them might incur on account of my child’s condition or treatment. This consent shall not give rise to, and is not intended to give rise to, a legal duty owed by the University to my child. I do hereby release and forever discharge the University of Notre Dame du Lac and its employees, agents, officers, trustees, affiliates and representatives from any and all liability of any kind, including liability resulting from the University’s own negligence, for any claim, demand, action, cause of action, expense (including hospital, treatment facilities, medical and mental health expenses), judgment or cost, including without limitation attorneys’ fees, co-pays or deductibles, which arise out of or relate in any manner to the exercise of authority or judgment pursuant hereto, or to the securing, oversight, administration or supervision of medical, mental health or other care or treatment on behalf of my minor child at any time, or in connection with any travel incident thereto.

♦Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(ID Number) (Group Number) (Member’s Name)

1. Has your child had any serious illnesses, injuries or medical conditions for which he or she may require (a) medical treatment or (b) University accommodation(s) while participating in the Program?

No: \_\_\_\_ Yes: \_\_\_\_ If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your child experienced any emotional, psychological or mental health issues or disorders for which he or she may require (a) counseling or other mental health treatment or (b) University accommodation(s) while participating in the Program?

No: \_\_\_\_ Yes: \_\_\_\_ If yes, please describe, including any treatment received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child suffer from any allergies (e.g. medicine, insects, etc.) or have any dietary restrictions or needs that could affect his or her health while participating in the Program, or that you feel the staff should be aware of?

No: \_\_\_\_\_ Yes:\_\_\_ If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child currently taking any medications that might impact his or her participation in the Program?

No: \_\_\_\_ Yes: \_\_\_\_ If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are your child’s immunizations up to date?

No: \_\_\_ Yes: \_\_\_\_ If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Advise immunizations received in the last 90 days: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Parent/Legal Guardian Date