MEDICAL AUTHORIZATION FORM

Participant Information

NAME _____

ADDRESS _____

DATE OF BIRTH _____

MEDICAL AUTHORIZATION

I authorize the faculty leader to give necessary hospital or medical facility permission for the above named person on my behalf if an emergency demands it and time prevents my direct participation.

The above-named individual is covered by the following health and accident insurance which provides coverage while living in the United States.

Company Name _____

Policy Number _____

Indicate below any known allergies and/or medications regularly taken.

Indicate below any medications that should NOT be taken.

_____

Indicate below any other special medical needs or problems.

_____

List the address and telephone number of two persons who can be contacted in case of emergency.

_____

_____

_____
Participant's signature

_____
Witness

_____
Parent/guardian's signature if under 18

_____
Date

Return to:
Department of _____
UNCA
One University Heights
Asheville, N. C. 28804

We honor the principles in the Americans With Disabilities Act and welcome participation of all individuals with disabilities.