HAMPTON UNIVERSITY
Theology Institute for High School Youth
HEAD, HEART AND HAND SUMMER INSTITUTE
"A Theological Education for Life"

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF A MINOR

(I) (We), the undersigned parent(s)/guardian(s) of _____, a minor, do hereby authorize the Hampton University Health Center or attending medical personnel as agent(s) for the undersigned to consent to any emergency examinations or treatment which is deemed advisable by, and is to be rendered under the general or special supervision of the Hampton University Health Center staff.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or emergency care to provide authority and power on the part of the Hampton University Health Center staff to give specific consent to all emergency treatment which the Hampton University Health Center staff, in the exercise of his/her best judgment, may deem advisable.

(I) (We) hereby authorize the Hampton University Health Center to provide treatment to the above-named minor pursuant to the provisions of Code of Virginia § 54.1-2969 – Section C and Section D - Authority to consent to surgical and medical treatment of certain minors.

These authorizations shall remain effective from June 25 until July 1, 2017, unless sooner revoked in writing delivered to said agent(s).

Signed: _____ Date of Signature_____
Parent/Guardian

Address: _____

City: _____ State: _____

Phone No.: Home (____) _____

Work (____) _____

Cell (____) _____

Funding Provided by: The Lilly Endowment, Inc.

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Emergency Information

IN CASE OF EMERGENCY NOTIFY: _____

Address _____ City _____State___ Zip _____

Phone: **Home** (____) _____ **Work** (____) _____ **Cell** (____) _____

IF DIFFERENT THAN ABOVE COMPLETE:

Father's Name _____

Address _____ City _____State___ Zip _____

Phone: **Home** (____) _____ **Work** (____) _____ **Cell** (____) _____

Mother's Name _____

Address _____ City _____State___ Zip _____

Phone: **Home** (____) _____ **Work** (____) _____ **Cell** (____) _____

MINOR'S PHYSICIAN

Name _____

Address _____ City _____State___ Zip _____

Telephone Number (_____) _____

Name of Medical Insurance Provider*_____

Policy # _____ Expiration Date _____

*__Attach a copy of your medical card__

If your son or daughter has a medical problem or is taking medication that would be important for us to be aware of, please indicate here:_____

_____

_____

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