



Sul Ross State University Talent Search - Trip Permission Form and Authorization for Medical Treatment



Student Name: _____ School: _____

As the parent/guardian of the above-named student, I hereby authorize the Talent Search Director and her authorized staff to furnish such diagnostic, medical and/or surgical treatment of my child as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the child. Sul Ross State University and its officers, regents, and employees shall not be liable in any way for any consequences from said diagnostic, medical, and /or surgical treatment and are hereby released from any and all claims and causes of action that may arise out of or is incident to such diagnosis, treatment or surgery to the extent allowed by law, except as provided for through the group medical insurance plan if the student contracted for the same prior diagnosis, treatment or surgery. Sul Ross State University Talent Search does not assume any financial or other responsibility but wishes to provide the best services possible in an emergency. In case of sudden illness or accident, I consent to emergency treatment by the professional medical/nursing staff available to my child. In case of serious illness/accident, I will be notified immediately, but if I cannot be reached, necessary interim emergency care may be provided by professional medical/nursing staff or by a physician/nurse designated by Talent Search. Furthermore, I agree to be at the designated time and place of drop-off and pick-up for all TS trips. I realize that if I fail to provide my child with punctual pick-up, he/she will lose the privilege of attending future TS trips.

PLEASE COMPLETE THE SECTION BELOW FOR YOUR FAMILY'S MEDICAL HEALTH PROVIDER:

Emergency Contact Person #1: _____ Relation: _____

Phone # for Contact Person: _____
Work _____ Home _____ Cell _____

Emergency Contact Person #2: _____ Relation: _____

Phone # for Contact Person: _____
Work _____ Home _____ Cell _____

Name of Insurance Company: _____ Policy # _____

Name of Family Physician: _____ Phone # _____

List any special medical conditions your child may have, including prescribed medicine(s) taken regularly: _____

Please check the appropriate spaces for over-the-counter medicine that can be administered to your child:

Ibuprofen Advil Aleve Tylenol Pepto Bismol Tums Benadryl

I, as the parent or guardian of the above named student, have read and agree to the statements above. In the event the emergency information changes, I will contact the Talent Search Office with those changes immediately.

Parent's Name (Printed) _____ Parent's Work # _____ Parent's Home # _____ Parent's Cell # _____

Parent's Signature _____ Date _____