☐ North Campus ☐ Kendall Campus ☐ Wolfson Campus ☐ West Campus
☐ Medical Center Campus ☐ Homestead Campus ☐ InterAmerican Campus ☐ Hialeah Campus

Permission for Emergency Treatment

This document and its contents constitute a student record and are exempt from public records under §1002.22 and §1006.52, Florida Statutes. The contents of this document can only be disclosed in accordance with the Student's and/or Parent(s)/Guardians consent.

STUDENT NAME _____ STUDENT NUMBER _____

I certify that I am over 18 years of age and am responsible for my own welfare. As indicated and signed above, I authorize the program director abroad and/or physician-in-charge to make the decision cooperate in case of medical emergency. I authorize the physician in charge to decide on appropriate medical treatment in any medical emergency. I hereby consent to Miami Dade College disclosing any and all of my medical information in its possession for the sole purpose of assessing my medical needs or obtaining medical services on the student's behalf.

Student's Signature: _____ Date: _____

FOR PARENT(S) GUARDIANS OF STUDENTS

I/We hereby authorize the appointed representative(s) of Miami Dade College to obtain and authorize medical treatment as is necessary to protect the well being of my child, including authorization for emergency treatment, anesthesia, and/or surgery as deemed necessary. Further, I/We do hereby release and agree to hold harmless Miami Dade College and its, Board of Trustees, directors, officers, employees and agents from any and all claims which may arise from said medical treatment. I/We hereby consent to Miami Dade College disclosing any and all of the student's medical information in its position for the sole purpose of assessing the student's medical needs or obtaining medical services on the student's behalf.

_____ _____
Student's Signature Date Signature of Parent/Guardian Date

Note: On rare occasions an emergency requiring hospitalization, surgery, and/or other medical treatment develops. Since in some countries/states student under the age of 21 might not be administered an anesthetic or operated on without the written consent of the parent or guardian, we request that the parent or guardian sign this document in order to prevent a dangerous delay in the administration of emergency medical attention.

The following request information shall be only disclosed to a healthcare provider should student require medical services and is unable to personally convey this information to the medical service provider.

Insurance Information

Name and address of student's medical insurance company valid in USA.

_____

Policy No. _____

Emergency Medical Information

Do you suffer from any of the following conditions?

___ Allergies ___ Asthma ____ Convulsion _____ Heart Trouble

___ Diabetes ___ Fainting Spells ____ Bleeding Disorders

___ Other (explain)

Do you wear?

___ Contact Lenses ____ Dentures

Are you currently taking any medications? (Please list)

_____

_____

_____

_____