CALIFORNIA STATE UNIVESITY MONTEREY BAY *and*
UNIVERSITY CORPORATION AT MONTEREY BAY

VOLUNTARY MEDICAL TREATMENT CONSENT AGREEMENT

The undersigned participant hereby authorizes staff members of the California State University Monterey Bay and the University Corporation at Monterey Bay to act as agents for the undersigned and to consent to any hospital care when any or all of the foregoing is deemed advisable by any physician licensed under the Medical Practice Act or by any dentist licensed under the Dental Practice Act. This authorization is given pursuant to the California Family Code Section 6910 in advance of any specific diagnosis, treatment, medical care or dental care being required.

****

I have read this Voluntary Medical Treatment Consent Agreement document and I am signing it freely. I understand that completing the Voluntary Medical Treatment Consent Agreement AND providing my Medical Treatment Information is voluntary and I have elected to opt in. **No other representations concerning the legal effect of this document have been made to me.**

Participant Signature: ______________________________________

Participant Name (print):____________________________________ Date: ________________________

If participant is under 18 years of age, the parent or legal guardian must complete the reverse side of this form.

****

MEDICAL TREATMENT INFORMATION

Personal Information (Please Print)

Student's Last Name_____________________ Student's First Name _________________MI_____ Date of Birth:____________

Phone number(s) where student can be reached:____

Address:____

City:________________________ State:______ Zip:___________

Do you know of any reason why you should be restricted in physical activity or do you have any other medical condition that you would like first responders to be aware of?____

____

Are you taking any medications that first responders may need to know about? ____

Do you have any allergies to food, bees, plants, animals, medications, or other substances? ____

____

Please note that if you have medical conditions that require preventative or emergency medications (Ex: inhalers, epiPENs, insulin, other), it is your responsibility to bring these required medications with you to all class activities.

Emergency Contact Information

Name:____ Relationship:__________________________

Address:____ City:______________ State:______ Zip:________

Home Phone:_____________________________________ Cell/Work Phone:___________________________

Insurance Information

You are responsible for any medical expenses incurred. Are you covered by health insurance? **Yes / No**

Insurance Co. Name:_______________________________ Policy #:________________________

Name of Insured: ___________________________________

Address:____ City:______________ State:________ Zip:________

Home Phone:(______)__________________________________ Cell/Work Phone:(___)______________________

Physician Information

Name_______________________________________

Address ____________________________________ City_____________ State__________ Zip _________

Phone: (______) _________________________ Alternative Phone: (______) ______________________

Please return to: School of Natural Sciences

If Participant is under 18 years of age, the parent or legal guardian must complete this section:

I am the parent or legal guardian of the Participant. I have read this Voluntary Medical Treatment Consent Agreement document and I am signing it freely. I understand that completing the Voluntary Medical Treatment Consent Agreement AND providing Medical Treatment Information for my minor participant is voluntary and I have elected to opt in. **No other representations concerning the legal effect of this document have been made to me.**

____
Signature of Minor Participant's Parent/Guardian

____ ____________________
Name of Minor Participant's Parent/Guardian (print) Date