Washington State University
Leadership-Vision-Partnership Program

Medical Treatment Authorization

I _________________, the legal parent/guardian of (_____________________) (Participant name), hereby authorize and give my consent Washington State University Health and Wellness Services, or any licensed medical professionals, to perform upon Participant any reasonably necessary or advisable medical treatment. In the event medical treatment is necessary, University authorities or licensed medical professionals will make a reasonable attempt to contact me before relying upon this authorization. If I cannot be contacted, I authorize WSU, its employees, and the treating licensed medical professionals to obtain or provide whatever medical treatment is deemed necessary for the Participant. This authorization is intended to cover minor and emergency treatment, surgeries, injections, blood transfusions, anesthetics, and operations and procedures.

This authorization does not entitle the licensed medical professional to render any medical or surgical treatment without Participant's personal consent, unless Participant is unable to give consent. This permission is good only while Participant is attending the Leadership-Vision-Partnership (LVP) Camp, unless revoked by myself or Participant in writing and only until Participant has turned eighteen years of age.

I understand that I will be responsible for any expenses in connection with Participant's attendance at the LVP Camp, including any medical treatment expenses.

AS CONSIDERATION FOR PARTICIPANT'S ENGAGEMENT AND PARTICIPATION IN LVP CAMP, I AGREE THAT I HAVE READ THIS AGREEMENT AND THE ATTACHED MEDICAL INFORMATION AND RELEASE FORM, I AM SATISFIED THAT I UNDERSTAND ITS CONTENTS AND SIGNIFICANCE, AND AGREE TO ITS TERMS.

______________________________	______________________________
Signature of Parent or Guardian	Printed Name
______________________________	______________________________
Relation to Participant	Date

Medical Information and Release Form

As parent/guardian of the Participant named below, I hereby authorize Washington State University and its authorized agents, including Leadership-Vision-Partnership Camp directors and staff, to obtain medical care for Participant under the terms of the Medical Treatment Authorization form. I know of no medical or physical problems which might affect Participant's ability to participate in LVP Camp.

Participant's Name ____________________________________ Birth Date ________________

Parent/Guardian's Name ____

Parent/Guardian's Address ____

Day Phone _______________ Evening Phone ______________ Emergency Phone ___________

Special Medical Conditions (attach additional page if necessary)

____

Allergies to drugs: ____ Yes ____ No If yes, please list: _____________________________

Allergies to foods: ____ Yes ____ No If yes, please list: _____________________________

Allergies to bee stings that require medication ____ Yes ____ No

Special dietary restrictions ____

Other pertinent information (including medications the student is currently taking)

Insurance Company Name ____

Insurance Company Address ____

Policy Number ____________ Group Number _____________ Subscriber's Name ___________

Family Physician ____________________________ Phone number ___________________________