Please fill out both sides of form *
I, ________________, hereby authorize George Mason University Student Health Services to render medical treatment, which in his/her judgment may be deemed necessary in the case of ________________.

(Name of minor or dependent: First and Last name)

- Student’s Allergies: ____________________________
- Medical History (i.e. Diabetes, Asthma, Seizures, etc.): ____________________________________________
- List any Medications that the student is currently taking: __________________________________________
- Date of last Tetanus Booster: ______________________

Student's Doctor's Name: ___________________________________________________________________________________
Doctor's phone number including area code: ___________________________________________________________________________________

Parent or Guardian Name: ____________________________________________________________

Home Phone Number: ____________________________________________________________
Work Phone: ____________________________________________________________
Address: __________________________________________ City _______________________, State _______ Zip _______

Person to call in case of an emergency, and phone number, if different than above:
Name: __________________________________________ Phone number: ______________________

_________________________________________ ____________________________
Parent's or Guardian's Signature Date

Insurance Information

Insurance Company: ____________________________________________________________
Policy No. __________________________ Group No. __________________________
Mailing address for claims: __________________________________________________
Subscriber's Name: __________________________________________________________
Subscriber's Address and Home Phone Number: __________________________________________________
Employment Address and Phone Number: ____________________________________________

*Please fill out both sides of form*