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*