2025 NCPIAC Emergency/Medical Treatment Consent Form

Approved Medical Procedures for:

First Name ____________ Last Name ____________ D.o.B. ____________

Emergency/Medical Treatment Consent Agreement

In the event of an emergency or for medical treatment, I hereby give my consent and authorize the University Health Service or the closest Hospital Emergency Department to provide medical services for me. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required, and is to serve as specific consent to any and all such diagnoses, treatment or hospital care, which may be deemed desirable.

Initials ____________ Date ____________

Emergency Contact Information

Primary Emergency Contact ____________ Relationship ____________ Phone Number ____________

Secondary Emergency Contact ____________ Relationship ____________ Phone Number ____________

Are you currently taking any medication?(If you answer yes, please describe below. If you are not, please indicate N/A)

Please list any other previous illness, injury, or surgeries.(If you do not, please indicate N/A.)

Please list any chronic illnesses or physical limitations. (If you do not have any, please indicate N/A.)

Do you have any allergies to drugs, medicines, plants, food, etc. (If you answer yes, please describe below. If you do not, please indicate N/A.)

Note: All participants must be fully vaccinated in order to participate in this conference! Please attach a copy of your proof of vaccination to this medical form! No one will be permitted on campus without proof of vaccination.

Health Insurance Information

Name of Insurance Company ____________ Policy Holder's Name ____________

I.D. or Contact Number ____________ Relationship to Policy Holder ____________

Service Code or Insurance Number ____________ Policy Holder's Phone Number ____________

Group Number or Policy Number ____________

Agreement

I request that payment under my medical
insurance program be made directly to the
sire of services rendered. I understand that I
am financially responsible for fees not
covered by this authorization.

By entering your initials below you agree to
the terms above and ensure that all information is correct.

Initials ____________ Date ____________