

Student's Name: _____ ID Number: _____

Springfield College Health Center
263 Alden Street / Springfield, Massachusetts 01109
(413) 748-3175 / (413) 748-3444 (fax)

MEDICAL EMERGENCY AUTHORIZATION FOR TREATMENT

EMERGENCY CONTACTS

Name of First Contact:
Relationship:
Address:
Home Telephone:
Work Telephone:
Name of Second Contact:
Relationship:
Address:
Home Telephone:
Work Telephone:

IN CASE OF MEDICAL EMERGENCY:

In the event that parents, guardians, or immediate family members cannot be reached, I hereby give permission to the hospital and / or Springfield College Student Health Center to secure proper treatment, anesthesia, or surgery for:

Student Name (please print): _____

Date of Birth: _____ Social Security Number: _____

Signature of Student (If student is 18 years or older) _____
Date

Signature of Parent/Guardian (If student is 17 years or younger) _____
Date