



Please return completed form to:

Continuing Professional Education
SUNYIT
P O Box 3050
Utica NY 13504-3050

Emergency Contact and Medical Information - SummerTeens at SUNYIT

_____ Child's Name		_____ Date of Birth		M	F
				Sex	
_____ Parent's/Guardian's Name		_____ Parent's/Guardian's Name			
() _____ Home Phone	() _____ Work Phone	() _____ Home Phone	() _____ Work Phone		
_____ Address		_____ Address			
_____ City, ST ZIP Code		_____ City, ST ZIP Code			

Alternative Emergency Contacts

_____ Primary Emergency Contact		_____ Secondary Emergency Contact	
() _____ Home Phone	() _____ Work Phone	() _____ Home Phone	() _____ Work Phone
_____ Address		_____ Address	
_____ City, ST ZIP Code		_____ City, ST ZIP Code	

Medical Information

Hospital/Clinic Preference

_____ Physician's Name	_____ Phone Number
_____ Insurance Company	_____ Policy Number

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

_____ Parent's/Guardian's Signature	_____ Date
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I release SUNYIT and individuals from liability in case off accident during activities related to SUNYIT, as long as normal safety procedures have been taken.

_____ Parent's/Guardian's Signature	_____ Date
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