

NOTE: ALL FORMS MUST BE SUBMITTED AS SOON AS POSSIBLE AND NO LATER THAN AUGUST 1ST FOR FALL ENTRY, JANUARY 1ST FOR SPRING ENTRY, AND MAY 1ST FOR SUMMER ENTRY

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:
Cell Phone:
Name of Second Contact:
Relationship:
Address:
Home Telephone:
Work Telephone:
Cell Phone:

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