



SUMMER ACADEMY IN APPLIED SCIENCE AND TECHNOLOGY
SCHOOL OF ENGINEERING AND APPLIED SCIENCE
UNIVERSITY OF PENNSYLVANIA

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR
AND
PROOF OF HEALTH INSURANCE

Name of Participant: _____

I hereby authorize representatives of the Summer Academy in Applied Science and Technology at the University of Pennsylvania to consent to emergency treatment for the Participant named below, including securing a medical evaluation and any treatment necessary to preserve life and bodily function unless exceptions are noted below.

This authorization shall remain in effect as long as the Participant is participating in the program.

Exceptions (if none, write "none"): _____

Participant is allergic to the following medications: _____

Other medical conditions that you wish for those providing treatment to be aware of:

Name and phone number of Participant's physician: _____

Signature of Parent or Guardian: _____ Date: _____

Print Name of Parent or Guardian: _____

INSURANCE INFORMATION

All participants in SAAST are required to show proof of health insurance. Please provide the information below, and in addition, **attach a photocopy of (both sides of) your membership card** or policy document to this form.

Name of insurance company _____

Policy or plan number(s) _____

Name of subscriber to policy or plan _____

Relationship to Participant _____