16TH ANNUAL NCSSSMST STUDENT RESEARCH SYMPOSIUM
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 NCSSSMST Student Research Symposium 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 the Symposium 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 _____________________________________________________________