MUHLENBERG COLLEGE HEALTH SERVICES

CONSENT FOR TREATMENT

STUDENT'S NAME _____

Parental/ Guardian permission must be obtained before medical treatment can be rendered to persons under 18 years of age. The following consent form should be signed by parent or guardian so that indicated care might be given with no unnecessary delay. No major procedures will be performed except in extreme emergency, without parents being notified and fully informed. In the event that a parent does not want treatment rendered under any circumstance, they should cross out the word "give" on the form below and insert the word "refuse". If the form is not signed, it will be interpreted as a refusal of permission.

Must be completed by student and parent/guardian: *"I give permission to the Consulting Physicians of Muhlenberg College to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my son/daughter (print name) _____ and in the physician's absence for the nurse on duty to render emergency care and other medical care in line with standing orders, and also permit such procedures to be carried out at and by one of the local hospitals in the event that my son/daughter has been sent or taken there for emergency care."*

_____	_____	_____
Signature of Parent/ Guardian	Printed name and relationship	Date
_____	_____	_____
Signature of Student	Printed name	Date

Must be completed by student: *"I give permission to the Consulting Physicians of Muhlenberg College to carry out such emergency diagnostic and therapeutic procedures as may be necessary for myself (print your name) _____ and in the physician's absence for the nurse on duty to render emergency care and other medical care in line with standing orders, and also permit such procedures to be carried out at and by one of the local hospitals in the event that I have been sent or taken there for emergency care."*

_____	_____	_____
Signature of Student	Printed name	Date

INSURANCE INFORMATION

INSURANCE DATA - Muhlenberg College carries a limited ACCIDENT insurance on all full time students. It is recommended that every student have primary insurance coverage. **Please include copies of Health and Pharmacy Insurance Cards (front & back).** *It is your responsibility to maintain current insurance information at the Health Center throughout your college career. It is also your responsibility to understand your health insurance plan (such as referral information, laboratory information, and in-network providers within the Allentown area). Students assume the cost of healthcare not provided by the health center. These include radiology & laboratory services (such as blood work and all cultures) and any outside health care provider evaluations.*

NAME OF INSURED _____

NAME OF INSURANCE CO. _____ TELEPHONE ( ) _____

GROUP NUMBER _____ IDENTIFICATION NUMBER _____

PRIMARY CARE PHYSICIAN'S (PCP) NAME _____ PCP
TELEPHONE ( ) _____ FAX ( ) _____

Are you a member of a Health Maintenance Organization (HMO)? _____Yes _____No
Do you have out-of-network coverage? _____Yes _____No
Is a health insurance referral required for evaluations by specialists? _____Yes _____No
Is a health insurance referral required for radiology services? _____Yes _____No
Does your Health Insurance require the use of a specific laboratory for laboratory services? _____Yes _____No
If "Yes", please specify name of laboratory. _____