MEDICAL EMERGENCY CARE AUTHORIZATION

Summer Community College Opportunity for Research Experience (SCCORE) Program

Name of Student:_____

Name/Number of relative who can be reached in case of emergency:
Phone #'s of Parent/Relative/Friend/Next of Kin:

Name	Contact Information
_____	_____ (cell/ home / work)
_____	_____ (cell/ home / work)
_____	_____ (cell/ home / work)

Address of Parent/Relative/Friend/Next of Kin:

_____
_____
_____

I, the undersigned, give permission for caring for the above named student to the following person(s): New Mexico Alliance for Minority Participation (New Mexico AMP) Staff member during the SCCORE Program.

Parent Signature:_____ Date: _____

Adult Student Signature: _____ Date: _____
(if responsible for own medical decisions/ responsibilities)

Witnessed By:
Name and Signature: _____

Phone Number: _____

Address: _____

Insurance Company (Medical) (if possible, please attach a copy of your insurance card)
Name of the Insurance Company: _____

ID # of Insured: _____

Phone Number of Insurance Company: _____

EMERGENCY CARE INFORMATION
Student's full name: _____
Student's Date of Birth: _____
Date of last Tetanus Shot of Student: _____
Student is allergic to the following medications: _____OR ____ None
Student is taking the following medications: _____OR____ None
Student is diabetic, has other chronic condition or major illness:

_____
_____

Name of primary care physician and phone number: _____

PARENT(S)/ADULT STUDENT: *Please note that you are responsible for all payment of medical treatment for your child(ren or yourself (if responsible for your own medical decisions/payments). New Mexico AMP does not carry medical insurance for students in the SCCORE program during his or her stay at the SCCORE Program. If you are responsible for your own medical decisions and responsibilities, please provide the pertinent information above to ensure medical treatment.*