



SAINT LOUIS
UNIVERSITY

CONSENT FOR EMERGENCY MEDICAL
TREATMENT IN CASE OF
ACCIDENT, INJURY OR SERIOUS ILLNESS

I consent to Saint Louis University employees and representatives making arrangements for emergency treatment for my child _____ by the staff of Saint Louis University, and/or by the staff of a licensed hospital or clinic if this is deemed necessary by the Saint Louis University staff. I understand that I will be notified of illness or injury as soon as possible.

In case of emergency please call: _____

HOME PHONE

WORK PHONE

OTHER PHONE

Are you covered by any health insurance company? Yes _____ No _____

If yes, name of insurance company: _____

Insurance company phone number: _____

Policy number, group number or medical card number: _____

Name of parent/legal guardian: _____

Please print or type

Signature of parent/legal guardian: _____

Signature of child/ward: _____

Date: _____

Form should accompany student at check-in.