



**Office of Study Abroad**  
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 Flint, MI 48502-1950  
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 Phone: 810-762-0867 Fax: 810-762-0006

**EMERGENCY MEDICAL TREATMENT  
 AUTHORIZATION FORM**

*If you are under the age of 18, your parent or guardian's signature is required. If you are over the age of 18, but are still a tax dependent of or living with your parent(s) or guardian, you must include the signature of the parent(s) or guardian.*

**MEDICAL AUTHORIZATION:** In the event that I/we cannot be reached to give my/our consent, I/we, the undersigned parent or guardian of \_\_\_\_\_ ("the student"), hereby authorize UM-Flint's representative to consent for me/us to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care for the student that is deemed necessary or advisable by a licensed physician during the period the student is enrolled in the Study Abroad or Off Campus Study Program

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of UM-Flint to give specific consent to the diagnosis, treatment or hospital care which is deemed advisable for the student in the best judgment of a licensed physician or medical professional.

**Authorization to Release Medical Records:**

I hereby authorize the release of any medical information that might be needed in connection with payment for medical services.

**Payment of Medical Expenses**

I/We understand that I/we are responsible for any costs incurred for medical diagnosis or treatment that are not covered by insurance.

I certify that I am the parent or legal guardian of the student named above, that I have read the preceding agreement and that I join the agreement without reservation, granting my consent to all actions provided for herein.

<b>SIGNATURES</b>		
Student Name	Signature	Date
Parent/Guardian Name	Signature	Date

**Please submit the original form to the Office of Study Abroad (219 UCEN).**