

MIT Medical Release Form

If you will be under the age of 18 when you visit MIT, we require that your parent/ guardian complete this two-page form and submit it to the Head Coach as soon as possible, but no later than four days prior to your visit. Please fax the completed and signed form to the attention of the Head Coach at **617-258-7343**.

Student's Name: _____
FAMILY/LAST NAME FIRST/GIVEN NAME MIDDLE NAME

Sport: _____

Home Address: _____
STREET

CITY STATE ZIP

Telephone: _____ **Birth Date:** _____
(AREA CODE) MONTH/DAY/YEAR

Cell Phone: _____
(AREA CODE)

Special medical problems/allergies to medications: _____

Father/Guardian: _____
FAMILY/LAST NAME FIRST/GIVEN NAME MIDDLE NAME

Business Address: _____
STREET

CITY STATE ZIP

Day Phone: _____ **Evening Phone:** _____
(AREA CODE) (AREA CODE)

Mother/Guardian: _____
FAMILY/LAST NAME FIRST/GIVEN NAME MIDDLE NAME

Business Address: _____
STREET

CITY STATE ZIP

Day Phone: _____ **Evening Phone:** _____
(AREA CODE) (AREA CODE)

Name of person with whom student resides: _____
(if different from above)

Family Physician/Practitioner: _____
Address: _____

STREET

CITY STATE ZIP

Day Phone: _____ **Evening Phone:** _____
(AREA CODE) (AREA CODE)

Date of Last Tetanus Shot: _____

Please complete the other side.

Student's Name: _____
FAMILY/LAST NAME FIRST/GIVEN NAME MIDDLE NAME

Student's Insurance Information:

Name of insurance provider: _____
Student's insurance ID number: _____
Group number (if applicable): _____
Name of primary subscriber/relationship to student: _____
Subscriber's date of birth: _____

List two adults to whom your child may be released if we are unable to contact parents/guardians.

Name: _____
FAMILY/LAST NAME FIRST/GIVEN NAME MIDDLE NAME

Address: _____
STREET _____
CITY STATE ZIP

Day Phone: _____ **Evening Phone:** _____
(AREA CODE) (AREA CODE)

Relationship: _____

Name: _____
FAMILY/LAST NAME FIRST/GIVEN NAME MIDDLE NAME

Address: _____
STREET _____
CITY STATE ZIP

Day Phone: _____ **Evening Phone:** _____
(AREA CODE) (AREA CODE)

Relationship: _____

In case of an emergency and if I/we cannot be reached, I/we the undersigned parent(s) or guardian(s) of the above-named minor, do hereby authorize a representative of Massachusetts Institute of Technology (MIT) and/or the alternates listed above to act as agent(s) to consent to any X-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care deemed advisable and rendered by any licensed physician or surgeon, whether in the practitioner's office or in a licensed hospital. This authorization is given in advance of any required care to empower a representative or official of MIT to give consent for such treatment as the physician may deem advisable. I/we understand that MIT does not provide accident medical insurance for my child. I/we understand that I/we will be responsible for any medical charges incurred that are not covered by insurance.

On: _____ **At:** _____
DATE LOCATION

In the event of a disaster, if parents/guardians are not available, my child may be released to an adult familiar to them (please select one): **Yes** **No**

Signature 1: _____
Signature 2: _____

Note: signature of both parents needed unless single parent or guardian with legal custody. If you are a single parent with legal guardianship, please bold your name.