

# 2025 NCPIAC Emergency/Medical Treatment Consent Form

Approved Medical Procedures for:

\_\_\_\_\_  
First Name                                      Last Name                                      D.o.B.

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## Emergency/Medical Treatment Consent Agreement

In the event of an emergency or for medical treatment, I hereby give my consent and authorize the University Health Service or the closest Hospital Emergency Department to provide medical services for me. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required, and is to serve as specific consent to any and all such diagnoses, treatment or hospital care, which may be deemed desirable.

\_\_\_\_\_  
Initials                                              Date

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### Emergency Contact Information

\_\_\_\_\_  
Primary Emergency Contact                      Relationship                      Phone Number

\_\_\_\_\_  
Secondary Emergency Contact                      Relationship                      Phone Number

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Are you currently taking any medication?(If you answer yes, please describe below. If you are not, please indicate N/A)

Please list any other previous illness, injury, or surgeries.(If you do not, please indicate N/A.)

Please list any chronic illnesses or physical limitations. (If you do not have any, please indicate N/A.)

Do you have any allergies to drugs, medicines, plants, food, etc. (If you answer yes, please describe below. If you do not, please indicate N/A.)

**Note: All participants must be fully vaccinated in order to participate in this conference! Please attach a copy of your proof of vaccination to this medical form! No one will be permitted on campus without proof of vaccination.**

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### Health Insurance Information

\_\_\_\_\_  
Name of Insurance Company                      Policy Holder's Name

\_\_\_\_\_  
I.D. or Contact Number                      Relationship to Policy Holder

\_\_\_\_\_  
Service Code or Insurance Number                      Policy Holder's Phone Number

\_\_\_\_\_  
Group Number or Policy Number

### Agreement

I request that payment under my medical insurance program be made directly to the sire of services rendered. I understand that I am financially responsible for fees not covered by this authorization.

By entering your initials below you agree to the terms above and ensure that all information is correct.

\_\_\_\_\_  
Initials                      Date