

CONSENT TO MEDICAL TREATMENT

The undersigned hereby consent(s) and grant(s) permission to representatives of Southeastern University, Inc. *for the*

Mission Trip to obtain emergency treatment on my behalf should I become unconscious or otherwise incapable of consenting personally to needed emergency medical treatment. The undersigned further consents to and hereby authorizes the appropriate medical authorities (i.e. hospital, physician, etc.) to administer such emergency medical treatment deemed advisable or necessary at the time of such emergency medical treatment and any subsequent treatment related to such emergency. This emergency medical treatment may include anesthesia (local and general) and any necessary additional treatments, operations, tests, transfusions, or injections that may be necessary or needed in the judgment of the hospital or treating physician.

The undersigned further agrees to be responsible to the supplier of the medical emergency treatment for the payment of any and all reasonable medical costs and fees associated with the care and rendering of emergency medical treatment.

Attach a photocopy of the insurance card for student's medical or hospital plan (for US Trips).
Any question that is not applicable, please indicate with "N/A".

Name of Attendee (please print) _____ Date of Birth _____

1. Medical History (include current treatment and current medication): _____

2. Are you sensitive to any drugs? _____ No _____ Yes Please list drugs _____

3. Immunizations: (Please include date of immunization. If you have not been immunized place "none".)
Tetanus Booster: _____ Polio: _____ Measles: _____

4. Check the illnesses you have had:
Chicken Pox _____ Measles _____ Mumps _____ Asthma _____ Scarlet Fever _____ Diphtheria _____ Malaria _____
Poliomyelitis _____ Tuberculosis _____ Diabetes _____ Heart _____ Stomach Ulcers _____ Epilepsy _____
List Allergies _____

5. Have you ever been under treatment for any mental illness or emotional disturbance? _____ No _____ Yes Date _____

6. Do you have physical limitations? _____ No _____ Yes Explain _____

I hereby acknowledge that I have read and understand the above Medical Consent Form. I further acknowledge and understand that Southeastern University, Inc. in no way will direct or conduct any medical treatment administered by medical authorities.

Attendee's Signature

Printed Name

Student ID: _____

Student SS#: _____

Date: _____