

# MIT Campus Preview Weekend 2009: Medical Release Form

THIS FORM MUST BE COMPLETED AND RETURNED BY APRIL 2, 2009

All students attending Campus Preview Weekend must complete and return this form by postal mail or fax. Please mail your completed form\* to MIT Office of Admissions, 77 Massachusetts Ave., Room 3-108, Cambridge, MA 02139-4307 or fax it to 617-253-4076 *no later than April 2, 2009*.

\*Parents must complete this form for students under the age of 17.

**Student's Name:** \_\_\_\_\_  
FAMILY/LAST NAME                      FIRST/GIVEN NAME                      MIDDLE NAME

**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.