NATIONAL HISPANIC INSTITUTE

NHI Medical Authorization Form and Waiver of Liability 2016-2017

(PLEASE PRINT CLEARLY)

STUDENT INFORMATION

First Name | Middle Name | Last Name | DOB:mo/day/yr

Home Address | City | ST | Country | ZIP

PARENT/GUARDIAN 1 INFORMATION

Full Name | Home Phone | Work Phone | Cell Phone

Home Address | City | ST | Country | ZIP

PARENT/GUARDIAN 2 INFORMATION

Full Name | Home Phone | Work Phone | Cell Phone

Home Address | City | ST | Country | ZIP

ALTERNATE EMERGENCY CONTACT INFORMATION

Full Name | Home Phone | Work Phone | Cell Phone

Full Name | Home Phone | Work Phone | Cell Phone

MEDICAL CONDITIONS (List any conditions that may affect the student's ability to participate fully in the program.)

CURRENT MEDICATIONS (List all medications currently being taken by the student.)***

*** IF SENDING STUDENT WITH MEDICATION, NOTIFY ADMISSIONS@NHIMAIL.COM PRIOR TO THE PROGRAM.

MEDICATION AND FOOD ALLEGIES/DIETARY NEEDS (List any food/medication allergies as well as any dietary needs.)

LOG IN to www.nationalhispanicinstitute.org with your student's email/password and upload this form in his/her account under FORMS or send to:

ATTN: NHI ADMISSIONS, P.O. BOX 220, MAXWELL, TX 78656, USA

512-357-6137 (TEL.); 512-357-2206 (FAX) OR ADMISSIONS@NHIMAIL.COM

PHYSICIAN INFORMATION

Physician Name | Clinic Name | Phone | Fax

INSURANCE INFORMATION (IF AVAILABLE)

Insurance Company | Phone Number | Group Number | Policy Number

Policy Holder's Name | Relationship | Home Phone | Cell Phone

Student Last Name | First Name | MI

I certify that the above information is true and correct.

I certify that I have fully disclosed any medical, physical, mental, or emotional conditions of my child that may affect his/her ability to participate fully in the program.

I understand that participation in the National Hispanic Institute program may include participation in routine physical exercise. I grant my permission for my child to participate in routine recreational or exercise activities that are part of the National Hispanic Institute programs.

I understand that it is my responsibility to inform The National Hispanic Institute of any changes to my child's medical condition or medication in writing at least 90 days prior to the start of the program.

In the event that my child becomes sick or injured during the program, I authorize the National Hispanic Institute to seek appropriate medical treatment and/or hospitalization as ordered or recommended by a qualified physician. This may include, but is not limited to the administration of an anesthetic, laboratory procedures, medical treatment, x-ray examination, or other hospital services. Consent is hereby granted to the attending physician(s), hospital(s), and or clinics to release necessary medical information to our local doctors and for use in claims for insurance coverage.

I accept responsibility for the cost of the cost of such treatment and agree to cooperate with the National Hispanic Institute, its employees or officers, its insurance carriers or other related entities to ensure payment for the cost of treatment.

I hereby release the National Hispanic Institute, its officers, agents, instructors, employees and volunteers for any and all illness, injury or accident incurred or suffered by said son/daughter while traveling to, attendance at, or participation in the program from the time of his/her departure from home until his/her return.

Signature of Parent/Guardian | Printed Name of Parent/Guardian | Date

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