

Post-Secondary Preparation Program

Medical/Dental Release

Name of Student: _____

This document will authorize the INSIGHT Program staff at Morehead State University to carry out the following actions regarding the medical/dental care of my child.

First, I authorize the INSIGHT Program staff to select and employ a qualified physician/dentist, and/or to use hospital facilities for the emergency treatment of illness or accident, including the MSU infirmary.

Second, I authorize the INSIGHT Program staff members to render such information as required by hospital admission rules and to sign as a competent adult such forms as may be necessary to permit examination and possible treatment.

I understand that (A) Physicians/Dentists are reluctant and sometimes unwilling to examine and treat patients without such authorized signatures, and (B) the INSIGHT Program staff will permit only routine and emergency procedures, and that major or prolonged treatment will be undertaken only with my specific permission, except when such permission is impossible to obtain within the limitation of time or other conditions.

I further understand that in the event of accident or illness, the best interests of my child will guide all actions of the INSIGHT Program staff.

Signature: _____ Date: _____

Relationship to student: _____