

**MEDICAL CONSENT FORM**

I consent to, and authorize any medical professional and others working under their supervision to provide medical treatment or care to me \_\_\_\_\_ for any injury or illness arising from or related to my  
(Print Participant's Name)

involvement or participation in the Covered Program and agree to pay any and all medical expenses, costs and other charges, and to release, discharge, indemnify, defend, and hold harmless the University of Hawai'i, State of Hawai'i, and their regents, officers, employees, agents and assigns from and against any and all liability, claims, demands or actions arising from or connected with such medical treatment or care.

I give permission to the University of Hawai'i to undertake any emergency/urgent treatment or medical care for me that may be deemed necessary for my health. Also, if my hospitalization is deemed to be medically necessary, I give permission for my hospitalization.

**Participant's Health Insurance**

The University of Hawaii requires participants to maintain personal health insurance. Please indicate private insurance coverage or Medicaid eligibility below.

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

If you do not have private insurance, have you applied for Medicaid? Yes \_\_\_ No \_\_\_ (If not, please do so.)

\_\_\_\_\_  
Signature of Participant                                  Print Name: \_\_\_\_\_                                  Date

**Participant's Emergency Contact Information:**

Home Phone # (\_\_\_) \_\_\_\_\_ Contact Name \_\_\_\_\_

Work Phone # (\_\_\_) \_\_\_\_\_ Contact Name \_\_\_\_\_

Cell Phone # (\_\_\_) \_\_\_\_\_ Contact Name \_\_\_\_\_

**Physician's Emergency Contact Information:**

Home Phone # (\_\_\_) \_\_\_\_\_ Contact Name \_\_\_\_\_

Work Phone # (\_\_\_) \_\_\_\_\_ Contact Name \_\_\_\_\_

Cell Phone # (\_\_\_) \_\_\_\_\_ Contact Name \_\_\_\_\_

**Physician's Exchange:** Phone No.: \_\_\_\_\_ -