

FAX COMPLETED FORM TO BEC STUDENT SERVICES – 503.644.3269

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT/ CARE WAIVER

I, _____ hereby authorize the following individual(s) who consent to any
(Student Name)
medical or surgical treatment in the event I cannot. (Contact must be 18 years of age or older)

Date: _____

1. _____ Authorized Emergency Contact Person	2. _____ Authorized Emergency Contact Person
_____ Relationship to Student	_____ Relationship to Student
_____ Home Phone Number	_____ Home Phone Number
_____ Work Phone Number	_____ Work Phone Number
_____ Address	_____ Address

I and/or guardian/parent also give my permission for the company nursing staff to provide medical care for _____ an employee of the Business Education Compact
Name of Student Intern
participating in an internship with _____ when appropriately needed.
(Name of Company)

_____	_____	_____
**Parent/Guardian Signature	Date	
_____	_____	_____
Home Phone Number	Work Phone Number	Cell Phone Number

Student Medical Insurance Information:

Family Physician: _____ Phone: _____

Health Insurance Company: _____ Phone: _____

Employer Sponsoring Ins: _____ Phone: _____

Group Name (if different than employer) _____ Subscriber Name: _____

ID Number: _____ Group/Plan Number: _____

List any known allergies, i.e. medicines, food: _____

I have no medical insurance coverage at this time: _____
Student Signature

**Report emergencies to the Business Education Compact:
Daytime Hours: (503) 672-7972 After hours & Weekends only: (503) 972-8144**