

**Lafene Health Center
Kansas State University
1105 Sunset Ave, Manhattan KS 66502**

LHC1300.3011form
AP Patient Care
Revised 4/08

Student's Full Name

ID#

Birthdate

To be completed for every minor enrolled in any course on the Kansas State University Campus who may require the services of any medical provider at Lafene Health Center. Return to: Lafene Health Center, KSU, 1105 Sunset Avenue, Manhattan, Kansas 66502 BEFORE the course is offered on campus.

I authorize _____ to consult medical authorities as they deem necessary in case of illness or accident of the above named minor.

I authorize a licensed Medical provider to perform any necessary treatment and diagnostic studies for the above named person.

I authorize that necessary emergency surgery, anesthetics, and medications may be administered and carried out on the above.

It is understood that every reasonable effort will be made to contact me in case of serious illness or if surgery is indicated.

Signed: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Home Phone Number: __ (____) _____ Work Phone Number: __ (____) _____

Insurance information for accident/hospitalization coverage: (Include a clear copy of the front and back of your insurance card.)

POLICY HOLDER FULL NAME: _____

POLICY HOLDER DATE OF BIRTH (MM/DD/YY): _____

POLICY HOLDER ADDRESS: _____

CITY, STATE, ZIP CODE _____

THE POLICY HOLDER IS YOUR: (please circle one) MOTHER FATHER LEGAL GUARDIAN

I understand Lafene Health Center's Insurance Department will file insurance claims for all medical services to the company listed on the insurance cards I have provided, with the exception of medications. The pharmacy files prescriptions electronically only at the time of pick up. I agree to inform the pharmacist if I have prescription coverage. I am aware that the policyholder will receive an explanation of benefits (EOB), which includes detailed information about the submitted charges. I hereby authorize Lafene Health Center's Insurance Department to release any medical or other information necessary to process claims with my insurance company.

I agree to notify Lafene Health Center's Insurance department if my insurance information changes or is terminated.

Student Signature _____ Date _____

Parent/Guardian signature: _____ Date: _____