Authorization for Medical Treatment

Please submit this completed form via email (global@jessup.edu) ASAP in order for your application to be considered complete.

Personal Information

Name: _____ Birth sex: ☐ Male ☐ Female

Date of birth _____ Age you will be on May 1, 2024:_____
MM DD YYYY

Do you have current health insurance: ☐ Yes, with this company: _____ ☐ No

Does Jessup have your health insurance information on file: ☐ Yes ☐ No

Medical History

DISCLAIMER: This information will only be used for emergency and team placement purposes. Information shared via this form will not be given to anyone outside the necessary Jessup and Global Outreach staff. With that in mind please know that **it is very important that all questions are answered honestly and accurately**, as failure to answer thoroughly may put you or another person at greater risk in a medical crisis. Please mark "Yes" or "No" if you have or haven't had the following conditions.

In your lifetime have you experienced or been diagnosed with any of the following beyond routine illness:

	Yes	No		Yes	No
Asthma/respiratory problems?	☐	☐	Nose bleeds?	☐	☐
Sinus problems?	☐	☐	Diabetes?	☐	☐
Racing heart or unusual beats?	☐	☐	Heart murmur?	☐	☐
Fainting spells?	☐	☐	Seizures?	☐	☐
High blood pressure?	☐	☐	Frequent headaches?	☐	☐
Chest pressure or pain?	☐	☐	Anxiety or Depression?	☐	☐
Shortness of breath?	☐	☐	Back trouble?	☐	☐
Heat exhaustion?	☐	☐	Stomach/abdominal pain?	☐	☐
Severe nausea or vomiting?	☐	☐	Earaches?	☐	☐
Ringing ears?	☐	☐	Hearing difficulties?	☐	☐

Please comment about any questions which have been checked "Yes":

Do you know your blood type: _____

Do you have any allergies to food or medication?

Prescribed Medication

Please list the name of the medication, dosage, and frequency with which it is taken and reason for use.

Precaution

Do you have any physical, emotional, or psychological concerns that may hinder you from being able to function freely as a member of a team in extreme physical or emotional conditions, cultural discomforts, etc? (These may include, but are not limited to things like anxiety issues, blackouts, dependence on prescription medications, fears, etc.)

Authorization for Treatment

I,_____, do hereby authorize the Global Outreach Staff and/or William Jessup University Staff, my Global Outreach Team Leader or our field partner to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care or service, which is deemed advisable and is rendered under the general or specific supervision of any licensed physician and surgeon, or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being rendered, but is given to provide authority and power on the part of the Agent in the event of my disability to give specific consent to any and all such diagnosis, treatment, or hospital care which the above mentioned physician, in the exercise of his/her best judgment, may deem advisable. I hereby authorize any hospital, which has provided treatment to the team member to surrender physical custody of the team member to the Agent upon completion of treatment. I understand that it is important for William Jessup University to have a thorough understanding of my physical and emotional health and certify that I have answered the above questions to the best of my knowledge.

Name: _____ Signature: _____

Date: _____