I/We, the undersigned, parent(s)/guardian(s) of _________________________________ a minor, do hereby authorize, Stanford University Staff, as agents for the undersigned, to consent to an X-ray, examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of, any physician and/or surgeon licensed in any of the United States, or, if in a foreign country and no physician licensed to practice in any of the United States is reasonably available, by a duly licensed physician deemed competent to render the necessary.

It is understood that this authorization is given in advance of any specific diagnosis treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforesaid physician in the exercise of his or her best judgment may deem advisable.

I understand that as a parent/legal guardian, I will be responsible for the cost of any service or treatment provided by Stanford.

This authorization shall be valid and effective from _________________, 2013 until _______________, 2013 unless revoked sooner in writing delivered to Stanford.

I understand that in order to provide timely and effective medical attention to a minor Stanford has requested the completion of the attached Voluntary Heath History Information.

I understand that this form is voluntary and I ( ) elect to, ( ) elect not to complete this form.

Signature:

Name Printed (Parent/Guardian):

Please submit all forms by email or fax to: Reunion Homecoming Registration Associate

Amber Engle
Email: adengle@stanford.edu
Fax: (650) 724-1552

Questions? 650-723-9373
**VOLUNTARY HEALTH HISTORY INFORMATION**

This information is confidential and will be used only in case of emergency.

<table>
<thead>
<tr>
<th>Child’s First Name</th>
<th>Last Name</th>
<th>Sex: M / F</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Is your Child Subject to: Yes or No

Does your child have or has ever had: Yes or No

<table>
<thead>
<tr>
<th>Colds</th>
<th>Heart Trouble</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sore throat</td>
<td>Sinus Trouble</td>
</tr>
<tr>
<td>Fainting spells</td>
<td>Hernia</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>Appendicitis</td>
</tr>
<tr>
<td>Convulsions</td>
<td>Has appendix been removed?</td>
</tr>
<tr>
<td>Cramps</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
</tr>
</tbody>
</table>

Date of child’s last tetanus vaccination:

Please identify child’s allergies, including allergies to food, medications, or drug reactions you know about:

Is your child currently under any type of medical treatment?

If yes, please describe:

Is your child currently taken any prescription medication?

If yes, please identify name of medication, dosage, times taken:

Please identify over-the-counter medications that we may administer. For example: Antacid, Aspirin.

Please list any disabilities or disorders that may affect your child’s participation, such as eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

Is there any history of behavior disorders or emotional disturbances, such as difficulties in relationships with authority figures or peers, or abnormally severe moodiness?

Has your child been under psychiatric treatment within the past three years?

Name, address and telephone number of child’s physician:

Remarks and any special instructions: