Authorization for Medical Treatment
College of Pharmacy and Health Sciences

As a condition of my participation in the **2025 Massachusetts Health Council WNE Health Leadership Program** to be held at Western New England University (hereinafter "Activity"), and so that I may receive the necessary medical treatment in the event of an emergency whereby I may sustain injury or illness during participation in the Activity, I authorize any Western New England University official to consent to and obtain necessary treatment or hospital care for such an injury or illness during the trip and I hereby release, discharge, indemnify, and agree to hold Western New England University, its successors, assigns, and other legal representatives, and its trustees, officers, employees, agents, or servants harmless in the exercise of its authority. I further hereby acknowledge that neither Western New England University, nor any of the persons named above have any obligation to seek such treatment.

MASSACHUSETTS HEALTH COUNCIL
WNE
HEALTH LEADERSHIP PROGRAM

Sponsored by the
Massachusetts Health Council

Should the need arise, the following information may be given to any healthcare provider:

PARTICIPANT

Name:_____

Permanent Address: _____

Allergies:_____

Pre-existing Conditions: _____

EMERGENCY CONTACTS

Name:_____

Phone: Daytime_____Cellular_____

Name:_____

Phone: Daytime_____Cellular _____

PARTICIPANT'S REGULAR PHYSICIAN

Name:_____

Phone:_____

I have read and understand the above Authorization for Medical Treatment:

Participant's Printed Name:_____

Participant's Signature: _____

Parent/Guardian Printed Name:_____Date:_____

Parent/Guardian Signature:_____Date:_____

Mail or email form to:

College of Pharmacy and Health Sciences
Western New England University
1215 Wilbraham Road
Springfield, MA 01119
healthprofessions@wne.edu
Phone: **413-796-2442**