

Non-Credit Programs  
Western Illinois University  
Medical Form

Student's Name \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

**Parent or Guardian Information During Period of Summer Program**

Father's Name \_\_\_\_\_

Business Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_

Mother's Name \_\_\_\_\_

Business Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_

Child's Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

In an emergency, if a parent cannot be reached, who should be contacted?

Name \_\_\_\_\_ Phone \_\_\_\_\_

Has this child any physical disability that we should know about?

NO \_\_\_\_\_ YES \_\_\_\_\_ Please specify: \_\_\_\_\_

Please rate your child's ability to swim: Cannot Swim \_\_\_\_\_ Poor Swimmer \_\_\_\_\_

Fair Swimmer \_\_\_\_\_ Good Swimmer \_\_\_\_\_ Excellent Swimmer \_\_\_\_\_

Does he/she have any allergies? Food \_\_\_\_\_ Pollen \_\_\_\_\_ Insect Bite \_\_\_\_\_ Medication \_\_\_\_\_

Please describe: \_\_\_\_\_

Any dietary restrictions not previously listed? \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Is he/she presently under a doctor's care? NO \_\_\_\_\_ YES \_\_\_\_\_

If yes, please specify: \_\_\_\_\_

Does he/she take regular medication? NO \_\_\_\_\_ YES \_\_\_\_\_

If yes, specify and include dosage: \_\_\_\_\_

Can your child monitor his/her own medications and take as directed?

NO \_\_\_\_\_ YES \_\_\_\_\_

Can your child take the following if the need arises?

Tylenol NO \_\_ YES \_\_ Pepto-Bismol NO \_\_ YES \_\_ Benadryl NO \_\_ YES \_\_

Medical insurance that would cover student during the program in the event of sickness or accident:

Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

I (we) \_\_\_\_\_, parent(s)/legal guardian(s) of \_\_\_\_\_, a minor, consent to medical, surgical, or diagnostic procedures as the physician deems necessary to be rendered to this minor when the need for such treatment is immediate. I understand that summer program fees do not include health or accident insurance coverage.

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

**Please return this form with photocopies of your MEDICAL AND PRESCRIPTION BENEFITS cards to:  
Non-Credit Programs, Horrabin Hall 6, Western Illinois University, 1 University Circle, Macomb, IL 61455**