

STUDENT HEALTH HISTORY AND PARENT CONSENT FORM

Upward Bound Program – Eastern Kentucky University

Student's Full Name _____ Birthdate _____
Last First MI

Parent/Guardian Name _____ Relationship _____

Mailing Address _____

Home Phone () _____ Work Phone () _____ Cell () _____

Health Insurance Carrier _____ Policy # _____

Student's Physician _____ Physician's Phone () _____

Does the student have any limiting physical or health disabilities (whether temporary or permanent) that you or your doctor feel would limit safe participation in the Upward Bound activities? Yes ____ No ____

If yes, please indicate:

Does the student have any chronic or recurring injuries? Yes ____ No ____

Has the student had a kidney transplant? Yes ____ No ____

Is the student pregnant? Yes ____ No ____

Health Checklist: Please check the following physical disabilities or conditions that may limit the student's participation:

- | | | |
|---|---|--|
| <input type="checkbox"/> Hearing or vision problems | <input type="checkbox"/> Recent hospitalization | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Serious reaction to high or low temperatures | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Frequent muscle cramps | <input type="checkbox"/> Other (specify below) |
| <input type="checkbox"/> Joint problems | <input type="checkbox"/> High or low blood sugar | |
| <input type="checkbox"/> Recent serious illness | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Recent surgery | | |

Allergies: indicate any allergies (including medications), your reaction, and treatment:

Allergy	Reaction	Treatment

Medications: Please indicate all medications currently taking, for what, and will it be needed during Upward Bound activities. If so, make sure student has medication with them.

Medication	Condition	Needed during program activities?
		Yes ____ No ____
		Yes ____ No ____
		Yes ____ No ____

Additional Emergency Contact Information:

In the event of an emergency, and the parent/guardian cannot be reached, please indicate another emergency contact below:

Print Full Name	Relationship	Phone Number
-----------------	--------------	--------------

I hereby give permission for _____, to participate in the Upward Bound Program activities during the 2011-2012 academic year beginning September 1, 2011 thru August 30, 2012.

In case of an injury, I grant permission for _____ to receive medical attention deemed necessary, by qualified medical personnel, during the entire time that he or she (listed within) is participating in the Eastern Kentucky University, Upward Bound Program.

PARENT/GUARDIAN: Every reasonable precaution will be taken to provide safety and care for your son/daughter. Every effort will be made to notify you in the event of an accident or injury, which may require emergency care. If you cannot be contacted, permission is granted to the staff to seek medical attention. All financial responsibility for hospitalization and medical care provided, in the case of an emergency, is to be assumed by the parent or guardian.

Signature of Parent/Guardian (if student is under the age of 18)	Date
--	------