



Upward Bound Programs
 California State University, Fresno
 University Center 124
 5240 N Jackson M/S UC59
 Fresno, CA 93740-8023

Office: (559) 278-2693 or (559) 278-5796 * Fax: (559) 278-4306

MEDICAL CONSENT AUTHORIZATION FORM
 Summer Program 2013

The undersigned parent (or guardian) of _____, whose birth date is _____, hereby
 (Name of Student)
 authorizes staff members in the Upward Bound Programs at California State University Fresno to seek and authorize medical treatment for my son/daughter in the event of an emergency. If an emergency arises requiring a major surgical procedure, the program staff will attempt to reach me to be guided by my wishes; but if I cannot be reached, I authorize the attending physician to proceed as deemed advisable.

Date _____ Signature _____
 (Parent or Guardian Signature)

Telephone Number (____) _____

Is the student allergic to any medication? Yes No

If yes, please specify _____

If the student has any special medical problems(s), please specify below and give any special instructions: _____

Emergency Contact

Name _____ Relationship to Minor _____

Address _____
 (Street or P.O. Box) City, State Zip Code Apt #

Emergency Contact Phone Number: _____

PLEASE FILL OUT BOTH SIDES → → →

HEALTH HISTORY

Student Name _____ Age _____ Grade _____

Address _____ City _____ Zip _____

Date of last general medical examination: _____

Has he/she had a serious illness or operation in the past? Yes ___ No ___

If yes, please describe: _____

Has your son/daughter had recent exposure to any contagious disease? Yes ___ No ___

If yes, which one? _____ When? _____

Has your son/daughter ever had any of the following illnesses? Please check all that pertain.

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Stomach Upsets |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> other |

Is your son/daughter allergic to any of the following illnesses? Please check all that pertain.

- | | |
|---------------------------------------|---------------------|
| <input type="checkbox"/> Plants | (please list) _____ |
| <input type="checkbox"/> Foods | (please list) _____ |
| <input type="checkbox"/> Insect Bites | (please list) _____ |
| <input type="checkbox"/> Medication | (please list) _____ |

**Explain problem and details on how to handle questions on illness and/or allergies:

Date of last tetanus injection: _____

Is he/she taking any prescribed medication? If so, fully explain dosage, times to be given, and reason for medication: _____

Any medications taken to the Summer Program must be checked with the Director and Dorm Supervisor with all instructions fully explained and signed by parents. NO medication can be given without written permission from parent.

Name of Family Physician/doctor: _____ Phone: (____) _____

****THIS FORM IS TO BE FILLED OUT BY A PARENT OR GUARDIAN ONLY**