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 ➔ ➔ ➔

Updated 5/15/13 - NL

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

___ Asthma	___ Epilepsy	___ Rheumatic Fever
___ Bed Wetting	___ Fainting Spells	___ Sinus Infection
___ Convulsions	___ Heart Trouble	___ Sleep Walking
___ Cramps	___ Kidney Trouble	___ Stomach Upsets
___ Diabetes	___ Nose Bleeds	___ other

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

___ Plants (please list) _____

___ Foods (please list) _____

___ Insect Bites (please list) _____

___ 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