UPWARD BOUND PROGRAMS
California State University, Fresno
5240 North Jackson Ave M/S UC59
University Center #124
Fresno, CA 93740

FRESNO STATE
Upward Bound Programs

Phone 559.278.2693 Fax 559.278.4306

Medical Consent Authorization Form
2012-2013

The undersigned parent (or guardian) of _____whose birthday is on
(Name of Student)
_____, hereby authorizes staff members in the Upward Bound Program 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 and appropriate.

Parent or Guardian's Name:_____
(PRINT)
Parent or Guardian:_____ Date:_____
(SIGNATURE)

Home Telephone Number:_____ Student Cell Phone:_____
Father Cell Phone:_____ Mother Cell Phone:_____
Emergency Contact: Please give us the name, address, and phone number of someone we may call in the event of an illness or injury, someone who will know where and how to reach you – if the parent/guardian can't be reached.
Name:_____ Relationship to Minor:_____

Address:_____ Telephone Number:_____

Is the student allergic to any medication? Yes _____ (Specify _____) No_____

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

_____

_____

_____

_____

_____

PLEASE FILL OUT THE OTHER SIDE

Student Name: _____ Age: _____ Grade: _____School:_____

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 appropriate box (es):

☐ Anemia	☐ Epilepsy	☐ Nose Bleeds**
☐ Arthritis	☐ Fainting Spells**	☐ Rheumatic Fever
☐ Asthma**	☐ Glaucoma	☐ Sinus Infection
☐ Bed Wetting	☐ Heart Trouble	☐ Sleep Walking
☐ Convulsions**	☐ High Blood Pressure	☐ Stomach Upsets
☐ Cramps	☐ Kidney Trouble	☐ Tuberculosis
☐ Diabetes	☐ Migraine Headaches	☐ Other

Is your son/daughter allergic to any of the following? If yes, please check appropriate box (es):

☐ 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 Doctor: _____Telephone Number:_____

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

Student Signature: _____Date:_____

Parent Signature: _____Date:_____