

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

HEALTH HISTORY

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):

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nose Bleeds** |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting Spells** | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma** | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Convulsions** | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Upsets |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Other |

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

- | | |
|---|---------------------|
| <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 Doctor: _____ Telephone Number: _____

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

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____