SHEPHERD UNIVERSITY

UPWARD BOUND PROGRAM

EMERGENCY MEDICAL CONSENT / CONTACT FORM

I give consent during my child's entire enrollment in the program for him/her to receive emergency medical services, if necessary.

_____

Parent/Guardian Signature *Date*

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION.

STUDENT INFORMATION:

_____

Student's Last Name First Name M.I. Birthdate

_____

Street Address City State Zip Code

Gender: [ ] Female [ ] Male Social Security Number: _____

EMERGENCY CONTACT INFORMATION:

_____ _____

Parent's/Guardian's Last Name First Name Parent's/Guardian's Last Name First Name

_____ _____

Home Phone Number Work Phone Number Home Phone Number Work Phone Number

In the event that Upward Bound Staff cannot reach the parents/guardians, the following person(s) should be contacted:

_____ _____

Contact's Last Name First Name Contact's Last Name First Name

_____ _____

Contact Phone Number Relationship Contact Phone Number Relationship

MEDICAL HISTORY:

_____

Name of Family Physican Address Phone Number

On the back of this form, please list the medication, if any, taken on a regular basis, purpose of medication, time of day medication is taken, possible side effects. It is the parent's/guardian's responsibility to update his/her child's medication record.*

*Staff members will not dispense aspirin, Tylenol, any other over-the-counter drugs, or any medication to students.

List of Medications

Medications should not, if at all possible, be brought to Upward Bound activities. In the event medications must be brought to an activity, all medications must be in the prescription bottle with original pharmacy label, and Upward Bound Staff should be notified the medication is with the student.

Medication Name: _____ Dosage: _____

Purpose of Medication: _____

Time of Day Medication is Taken: _____

Possible Side Effects: _____

Anticipated Number of Days Medication will be Taken: _____

Medication Name: _____ Dosage: _____

Purpose of Medication: _____

Time of Day Medication is Taken: _____

Possible Side Effects: _____

Anticipated Number of Days Medication will be Taken: _____

Medication Name: _____ Dosage: _____

Purpose of Medication: _____

Time of Day Medication is Taken: _____

Possible Side Effects: _____

Anticipated Number of Days Medication will be Taken: _____

List of Allergies

Please list all allergies (food, medical, etc.) this student has. If the student has no known allergies, please put "None."

_____

Form completed by: _____ _____
Parent/Guardian Name Date

Form completed by: _____ _____
Parent/Guardian Name Date

Form reviewed by: _____ _____
Upward Bound Staff Member Name Date

Please up-date this record as needed. *Revised 2/27/2018*