Norfolk State University
Classic Upward Bound Program
Medical Consent Form

STUDENT HEALTH RECORD AND AUTHORITY TO RENDER MEDICAL SERVICES

The following is required for your health file. The information is strictly confidential and accessible only as needed by the Classic Upward Bound Program, Norfolk State University officials or medical personnel to provide medical treatment or to restrict activities. **Please complete each item fully and accurately and be sure to complete the reverse side. This form is not valid without the proper signatures.**

Name_____ Date_____

Address: _____City_____State_____Zip Code_____

Telephone: Home ( ) _____ Parent Cellular ( ) _____

Date of Birth ___/___/_____ Gender: (M) ____ (F) ____ Social Security Number_____

Indicate below by checking the diseases you have had:

____Measles ____Jaundice ____Whooping Cough ____Polio
____Chicken Pox ____Rheumatic Fever ____Mumps ____Tuberculosis

Operation(s):_____

Do you have, or have you ever suffered chronically from any of the following?

____Peptic Ulcer ____Asthma ____Heart Condition ____Convulsions ____Hay Fever ____Diabetes

Allergies (specify):_____

Injuries (specify), giving date of injury: _____

Allergic to any food (specify):_____

Do you have an eating disorder, specify: _____

Describe any special dietary requirements: _____

Do you have or had had an emotional illness? _____Yes_____No____ Are you receiving treatment? ____Yes No____

Are you taking medication(s)? _____Yes No_____
What, if any, mediation? _____Yes _____No

If you are, or have been under a physician's care recently for other minor illness, please describe: _____
_____

Describe any physical handicaps: _____

Any other personal or family medical history that may be of importance to your health records: _____
_____

EMERGENCY CONTACT INFORMATION

Primary Contact
Name_____
Phone Number(s) _____
Relationship to Student_____

Secondary Contact
Name_____
Phone Number(s) _____
Relationship to Student_____

Please complete the other side

ALL INFORMATION IS REQUIRED

Primary Physicians Contact Information

Physician's Name_____

Address_____ Telephone ( ) _____

AUTHORIZATION FOR MEDICAL TREATMENT

I attest that the health history information on my child is true and complete to the best of my knowledge. I agree to notify the Classic Upward Bound Coordinator or any other Classic Upward Bound Program's personnel in a timely fashion of any changes that may occur in my child's physical or mental health prior to participation in the summer program. I hereby grant permission to the Classic Upward Bound Program to authorize or furnish such medical care as the named student may require. Further permission for emergency treatment, i.e., major surgery, is granted, conditionally upon the understanding that the program will exercise all reasonable effort to contact the emergency reference (parent or guardian) named herein. Failure in such effort, however, should not prevent the program from providing such emergency treatment under the care of physician(s) contacted by the University as may be necessary for the best interest of the named student. I further understand and agree that Norfolk State University is not liable, financially or otherwise, for such emergency treatment except as provided through the group medical plan.

_____ _____
Participant's (Student) Signature Date

_____ _____
Insured Parent's Signature Date

Parent's Employer: _____

Name of Insurance Company: _____

Policy #:_____

Group#:_____

Medicaid#:_____

Note: A copy of the current medical insurance card or Medicaid card is REQUIRED – please attach.