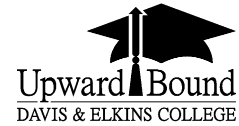
MEDICAL HISTORY, INFORMATION & CONSENT

PLEASE USE BLACK OR BLUE INK and complete both sides of form!



Student Name:

____ (Last) ______________________________ (First) ________ (MI)

Student Social Security #: ______________________________ **Birth Date:** ___________________ **Gender:** ____________

Please check one of the following pertaining to this student's medical insurance coverage.

Circle correct option: **I DO** or **DO NOT** have medical insurance (Private, Medical Card, or CHIPs) for the student.

PLEASE ATTACH A COPY OF THE HEALTH INSURANCE CARD or send a photo via email **deupwardbound@dewv.edu**

Name of Insurance Company: ____**Group #:** _________________

Policy or ID#: ____**Insurance Company Phone #:** _______________________________

Address of Insurance Company: ____

Please identify by name All adults and relationships in which the student resides or lives with (circle and identify):

Father: _________________________________ **Mother:** ____________________________ **Step- Mother:**__________________________

Step-Father: ____________________________ **Guardian(s):** ________________________________ (relationship) **Other:**__________________________ (relationship)

Mailing address: ____

Home #: ___________________ **Cell #:** ____________________ for _________________ **Cell #:** ________________ for _______________

Email (s): ____

Names of other children in home: ____

Student's Medical Doctor: _______________ **Doctor #:** ___________ **Student's Dentist:** ___________________ **Dentist #:** ___________

Circle any condition the student is being treated for by his/her physician below.

Respiratory:	Central Nervous System/Neurological:	Gastrointestinal:
• **Asthma with inhaler: Yes No** • **Chronic Bronchitis** • **Cystic Fibrosis** • **Severe Allergic Reaction Specify allergen:** _______________ • **Epinephrine: Yes No**	• **Cerebral Palsy** • **Epilepsy/Seizures Date of last seizure:** ______________________ **Seizure medications: Yes No** • **Brain/Spinal Cord Trauma/Infection** • **Hydrocephalic/Microcephalic** • **Migraine/Severe Headaches**	• **Cleft Lip/Palate** • **Ulcerative Colitis, Crohn's Disease** • **Eating Disorders (Anorexia/Bulimia)** • **Other GI problems:** _______________ • **Special Diet (Including food allergy/intolerance):** ______________________________
Behavior Medicine:	Endocrine:	Musculoskeletal:
• **Mental Disorders: Diagnosed Depression, Bipolar, Schizophrenia, Suicidal** • **Behavior Disorders: ADHD, Anxiety, OCD/ODD**	• **Diabetes Type 1** • **Diabetes Type 2** • **Hypoglycemia** • **Adrenal Insufficiency** • **Thyroid Disorder**	• **Juvenile Arthritis** • **Scoliosis, Lordosis, Kyphosis** • **Muscular Dystrophy** • **Osteogenesis Imperfecta** • **Spina Bifida** • **Prothesis**
Genetic:	Cardiovascular/Blood Disorders:	Urological:
• **Autism Spectrum** • **Down Syndrome** • **Tourette Syndrome**	• **Heart Problems** • **Hemophilia/Coagulation Disorder** • **Hepatitis** • **Hypertension** • **Immunosuppressed**	• **Renal Disease – Nephritis or Nephrotic Syndrome** • **Neurogenic Bladder**
Vision/Hearing:	Cancer:	Other: _____________________________
• **Glasses/Contacts** • **Color Blind** • **Hearing Aids** • **Other:**_________________	**Type:** _____________	**Or** **NO KNOWN HEALTH PROBLEMS**

*Please Circle **YES** or **NO***

YES or NO The student's immunizations are up to date.

YES or NO- The student's *Covid-19 Vaccine & boosters are up to date.*

YES or NO- The student has a communicable disease.

YES or NO- The student has a chronic illness.

Please explain any health or medical problems or physical limitations identified and recommendations of physician:

If the student has any allergies, please list any treatments, medications, or support equipment such as EpiPen, inhaler, glucose tablets:

Please explain any past illnesses, injuries, hospitalizations, or surgeries:

Please identify medications taken regularly:

If the student has any dietary restrictions or food allergies, please list below:

Any food allergies or dietary restrictions require completion of The Medical Plan of Care for School/Site Food Service Form *which is downloadable at deupwardbound.org* under the student info tab or *contact our office at 304-637-1389 or deupwardbound@dewv.edu We can mail or email you a copy of the form.* *We must have this documentation to share with our food service providers.*

Please identify all information you would like our staff to be aware. Be sure to note anything that could affect the student's participation in scheduled activities.

Please list another EMERGENCY contact (different than those identified)

Name: ______________________________ **Relationship:** ______________________

Address: ____

Home #: ____________________ **Cell #:** ________________________ **Work #:**____________________

I give Upward Bound staff permission to act in my place in the event of an emergency when I cannot be notified. Students and Guardians will report any medications taken as prescribed. I will update the program of any and all health changes regularly. In the event of any medical emergency, I authorize and consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment, and hospital care that UB personnel deem necessary for safety and protection. I understand and agree that Davis & Elkins College, Upward Bound, its employees and agents assume no responsibility for any injury or damage that might arise out of or in connection with such authorized emergency medical treatment and indemnify each of them of any claim arising out of the student's participation. Authorization of medical consent pertains to hospital treatment only and does not prohibit emergency care in the field. **The undersigned certifies that they are the parent, guardian or representative of person listed on document and has the legal authority to sign on behalf of that person.**

____ ____________________

Student Signature Date

____ ____________________

Guardian Signature Date

This form will stand in effect through completion of the Program unless changes in health, medical, insurance, guardianship, or initiatives occur. New forms are readily available at deupwardbound.org or by contacting the UB Office 304-637-1389.