MEDICAL HISTORY, INFORMATION & CONSENT
PLEASE USE BLACK OR BLUE INK and complete both sides of form!

Upward Bound
DAVIS & ELKINS COLLEGE

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

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 ordeupwardbound@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.

The following medications are provided to all Upward Bound students on an "as needed" basis. Please write "**NO**" beside any of these medications you **do not** want your child to receive.

_____Ibuprofen (Advil, Motrin, etc) ____Acetaminophen (Tylenol, etc) _____Pepto Bismol _____Dramamine _____ Benadryl (antihistamine)

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.

10/18/2023