UPWARD BOUND

MEDICAL/DENTAL RELEASE

This instrument will authorize the director of the Western Kentucky University Upward Bound program or any staff member of Upward Bound designated by the director, to carry out the following actions regarding the medical/dental care of _____
(student's name)
This authorization shall extend to any time when said student is enrolled in Upward Bound and participating in any Upward Bound sponsored program/event.

FIRST, I authorize Upward Bound to select and employ a qualified physician/dentist and to use local hospitals and clinics for the treatment of illness or accident. Further, I authorize Upward Bound to select and employ a qualified physician/dentist and medical facility in any other town or state that Upward Bound may be visiting.

SECOND, I authorize Upward Bound staff members to render such information as required by hospital admission rules and to sign, as a competent adult, forms permitting examination and possible treatments.

I understand that (a) physicians/dentists are reluctant and sometimes unwilling to examine and treat patients without such authorized signatures and (b) Upward Bound will permit only routine and emergency procedures and that major or prolonged treatment will be undertaken only with my specific permission, except when such permission is impossible to obtain within the limitations of time or other conditions.

I understand that I will be financially responsible for cost incurred for illnesses/injuries not covered by my medical insurance or the accident insurance provided by the Upward Bound program of Western Kentucky University.

_____ _____
Signature of Parent/Guardian Date

Telephone_____ If you do not have a telephone, please give a number where you can be reached in case of emergency: _____

Upward Bound will have accident insurance on your child. If you have medical insurance, please fill out the information below.

Name of Company_____

Name of Policyholder_____

Policyholder Identification Number_____

Group Number_____

KENPAC #_____

Name of hospital that accepts your Medical Insurance _____

UPWARD BOUND

HEALTH HISTORY

NAME: _____ SCHOOL: _____

NAME OF FAMILY DOCTOR: _____ TELEPHONE: _____

HEIGHT: _____ WEIGHT: _____

1. Please check any of the following that you have had or do have:

____Allergies
____Anemia
____Appendicitis
____Asthma
____Chicken Pox
____Diabetes
____Diphtheria
____Ear Disease
____Epilepsy
____German Measles (Rubella)
____HIV Disease
____Hay Fever
____Heart Disease
____Hepatitis
____High Blood Pressure
____Kidney Disease
____Malaria
____Meningitis
____Menstrual Disorders
____Mononucleosis
____Mumps
____Pneumonia
____Polio
____Red Measles (Rubeola)
____Rheumatic Fever
____Rupture or Hernia
____Scarlet Fever
____Sinus Infection
____Skin Disorders
____Tonsillitis
____Tuberculosis
____Ulcer
____Undulant Fever
____Venereal Disease

2. If you checked any item above please explain. _____

_____

3. Have you ever had a serious illness, injury, or operation not listed above? ____Yes ____No

If yes, explain: _____

4. Have you ever had treatment for mental or emotional illness? ____Yes ____No

If yes, explain: _____

_____

5. Do you have any physical impairment, i.e., paralysis, loss of vision, impaired hearing, etc.?

____Yes ____No If yes, explain: _____

6. Do you take any prescription medications regularly? ____Yes ____No

If yes, describe: _____

7. Are you sensitive (allergic) to any medications such as Penicillin, Tetanus Toxoid, or Sulfa drugs? ____Yes ____No

   If yes, please give the name of the medication and describe the reaction:_____

   _____

   _____

8. Are there any conditions which would limit your participation in physical activities?

   ____Yes ____No If yes, please explain:_____

   _____

9. Are you on a special diet? ____Yes ____No If yes, please include a copy of your diet.

10. Have you had a physical exam within the past year? ____Yes ____No

11. Are you seeing a doctor for any reason? ____Yes ____No If yes, explain:_____

    _____

    _____

_____ _____

Signature of Parent/Guardian Date