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 ____________________________
NAME: _________________________________________ SCHOOL: __________________

NAME OF FAMILY DOCTOR: _______________________ TELEPHONE: ________________

HEIGHT: _________________   WEIGHT: _________________

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

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