

EMERGENCY MEDICAL INFORMATION

Student's Name: _____
(First) (Middle) (Last)

Home Address: _____

Home Phone Number: _____ SSN: _____

Father's Name: _____ Work Phone Number: _____

Place of Employment _____ Cell Phone: _____

Mother's Name: _____ Work Phone Number: _____

Place of Employment _____ Cell Phone: _____

Medical Insurance Company: _____

Policy Number: _____

Family Doctor: _____ Phone Number: _____

Allergies (including food and drugs):

In case of an emergency and parent/guardian cannot reached, who may we contact?

Name and phone number: _____

MEDICAL TREATMENT PERMISSION

Check the appropriate place whether you give your permission to Upward Bound program staff to authorize medical or surgical treatment in the event it is not possible to contact you in the case of an emergency. It is understood that the Upward Bound program will make these arrangements without financial responsibility.

I give my permission for the Upward Bound program staff to authorize the following treatment to _____.

Emergency Medical Treatment () Yes () No
Emergency Surgical Treatment () Yes () No

(Parent/Guardian Signature)

(Date)