University of South Alabama
Emergency Medical Information

Both pages of this form must be included with the application for Summer STEM CAMP.

Student Information:

Name: _____

Address: _____
Street City State/Zip Code

Student Phone Number: ( ) _____ Sex: _____

Age: _____ Birth Date: _____

Name of School Attended 2017-2018 School Year: _____

Rising Grade for 2018-2019 School Year: _____

Parent/Guardian Contact Information:
This information will be used in case of an emergency

Parent/Guardian Name: _____

Is their address the same as above? Y / N

If no, please write their address below:

Address: _____
Street City State/Zip Code

Parent/Guardian Cell Phone Number: ( ) _____

Parent/Guardian Home Phone Number: ( ) _____

Parent/Guardian Work Phone Number: ( ) _____

Relationship of Parent/Guardian to Student: _____

Secondary Emergency Contact
This information will be used in case of an emergency if the primary guardian cannot be reached.

Name of Secondary Emergency Contact: _____

Secondary Emergency Contact's Primary Phone Number: ( ) _____

Secondary Emergency Contact's Alternate Phone Number: ( ) _____

Relationship of Secondary Emergency Contact to Student: _____

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Check below any information you feel the staff may need to maximize the safety and the well-being of your child. Beneath this section is space for more information relating to the condition checked. Please be specific. In case of emergency, this health information may be the only source of accurate important information. This information is confidential.

Y / N Mental or Emotional Health Issue

Y / N Seizure Disorder

Y / N Lung Disease (asthma, persistent cough, tuberculosis)

Y / N Disease of heart or blood vessels, increased or abnormal blood pressure

Y / N Pain in chest or shortness of breath (heart murmur, rheumatic fever)

Y / N Stomach or intestinal trouble (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)

Y / N Arthritis, Diabetes, Kidney or Bladder Disease

Y / N Hay fever or allergies

Y / N Impaired sight or hearing, chronic ear infections

Y / N Recent surgical operations, accidents, or injuries

Y / N Any current infectious disease

Y / N Any current skin disease

Y / N Significant Orthopedic and/or Neuromuscular Impairment

Y / N Allergy to foods

Y / N Allergy to medicines (including penicillin, tetanus)

Y / N Other _____

___ None of the above

If you marked yes to any of the above, please elaborate.

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Yes / Sometimes / No Does the student wear glasses?

Y / N Does the student wear contact lenses?

Date of Students last Tetanus Booster: _____

Medicines currently taken by student, including non-prescription or over-the-counter

medications (list names, doses, times):

Please list any medications that need refrigeration: _____

Y / N Is the student under the on-going care of a physician for chronic or recurring problems?

Nature of Chronic or reoccurring problem: _____

Doctors Name: _____ Clinic/Hospital: _____

Clinic/Hospital Address: _____

Street City State/Zip Code

Clinic/Hospital Phone Number: ( ) _____

Health Insurance Provider Name: _____

Policy Number: _____

Group Number: _____

Permission for Medical treatment/Statement of Insurance:
As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care will be given. I further understand that in case of serious illness/injury, I will be notified. However if it is impossible to contact me, I give my permission for emergency treatment, x-ray or surgery, as recommended by an attending physician.

I also understand that if my child becomes ill or injured, my health insurance is coverage for those expenses.

I agree: _____

I disagree: _____

Email: _____

Date: _____