Muskegon Community College

TRIO Upward Bound Project
Medical Statement

The following information is necessary if we are to provide the best medical and health services for each participant. Unless changes in the student's health occur, this form will remain in effect for as long as the student is involved with the Upward Bound Project. Applicants will not be excluded from the project because of health factors, but the director and staff should be aware of any special conditions that must be considered or avoided.
NOTE: This form must be notarized.

Student's Full Name: _____ Date of Birth: _____
First Middle Last

Name of person completing this form: _____ Relationship to student: _____

Emergency Contact: _____ Relationship to student: _____

Home Phone: _____ Work/Cell Phone: _____

Primary Care Physician:_____ Office phone: _____

Student's Medical History

General Health: _____ Any current health problems or injuries? _____

Allergies? (Medicine, Food, or other) _____

Current medications? _____

Has student ever been seriously ill, had serious injuries, or had surgery? _____ If yes, describe below.

_____

RELEASE OF INFORMATION/CONSENT OF TREATMENT

I HEREBY GRANT PERMISSION for the information provided on this form to be used if necessary as an aid to provide the necessary health care while my child is a student in the Upward Bound Project.
I UNDERSTAND that should a health emergency arise, I will be notified, but if I cannot be reached by telephone, such x-ray examination, medical, dental, or surgical diagnosis or treatment and hospital services as deemed necessary by competent medical personnel is authorized.

AUTHORIZATION FOR PRESCRIBED/ OVER THE COUNTER MEDICATION OR TREATMENT

The following is necessary for any student to use prescribed or over the counter medications or to receive treatment while participating in Upward Bound activities.
I AM REQUESTING PERMISSION for my child to use medication that has been prescribed to him/her. I will assume responsibility for safe delivery of the medication to the Upward Bound staff. I will notify the Upward Bound staff immediately if there is any change in the use of the prescribed medications or treatments. I also am acknowledging that my child may receive over the counter medications for headaches, upset stomachs, etc. from the Upward Bound staff. Additionally, should my child require medical treatment while participating in Upward Bound activities, I agree to authorize the Upward Bound staff to act in the best interests of my child until I can be reached.
I release and agree to hold Upward Bound, Muskegon Community College and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

SIGNATURE: _____ DATE: _____ PHONE: _____

ADDRESS: _____

NOTARY: _____ DATE: _____ TERM: _____