

MEDICAL TREATMENT AUTHORIZATION

All minors who are involved in University-sponsored programs, programs held at the University and/or programs housed in University facilities, are required to have their parent/guardian complete this document and return it to the University. The information on this document will be shared on a need to know basis only, and will otherwise be kept confidential.

Name_____ Date of Birth____/____/____ Gender____ E-Mail_____

Address_____ City_____ State_____ Zip_____

Mother_____ Father_____ Guardian_____

Home Phone_____ Home Phone_____ Home Phone_____

Work Phone_____ Work Phone_____ Work Phone_____

Cell Phone_____ Cell Phone_____ Cell Phone_____

List the following information for the person who carries medical insurance on the participant:

******Please provide a copy of the insurance card******

Full Name_____ Employer_____

Address_____ City_____ State_____ Zip Code_____

Insurance Co._____ ID, Group & Plan Nos. _____

******Please provide a copy of the insurance card******

MEDICAL HISTORY OF PARTICIPANT

CURRENTLY HAS (OR HAS EVER HAD)

	NO	YES
1. ALLERGIES TO FOODS	___	___ SPECIFY_____
2. ALLERGIES TO MEDICATIONS	___	___ SPECIFY_____
3. ENVIRONMENTAL ALLERGIES	___	___ SPECIFY_____
4. ASTHMA (OR OTHER RESPIRATORY ILLNESS)	___	___ SPECIFY_____
5. DIABETES	___	___ SPECIFY_____
6. SEIZURE/EPILEPSY	___	___ SPECIFY_____
7. HEART OR BLOOD PRESSURE CONDITION	___	___ SPECIFY_____
8. ORTHOPEDIC ISSUES REQUIRING MEDICAL ATTENTION	___	___ SPECIFY_____
9. ANY CONDITION LIMITING STRENUOUS ACTIVITY	___	___ SPECIFY_____
10. SERIOUS ILLNESS/INJURY REQUIRING HOSPITALIZATION	___	___ SPECIFY_____
11. ATTENTION DEFICIT DISORDER (ADD) or AD/HD*	___	___ SPECIFY_____
12. A PSYCHIATRIC DIAGNOSIS (such as depression, OCD, panic/anxiety disorder, eating disorder)*	___	___ SPECIFY_____
13. EMOTIONAL HEALTH CONCERN*	___	___ SPECIFY_____
14. SEEN OR IS CURRENTLY SEEING A PROFESSIONAL TO ADDRESS MENTAL/EMOTIONAL CONCERNS*	___	___ SPECIFY_____

*If you answered "yes" to statements 11-14 above, please attach a separate sheet providing details.

ANY OTHER HEALTH RELATED ISSUE(S): SPECIFY _____

DAILY MEDICATIONS (NAME, DOSAGE, TIMES, CONDITION MEDICATION TREATS)

SPECIFY _____

AS NEEDED MEDICATIONS (NAME, DOSAGE, FREQUENCY, CONDITION MEDICATION TREATS)

SPECIFY _____

Is this person normally aware of his/her own health care needs? Yes _____ No _____

Additional Information: Please provide in the space below any additional information about the participant's health that you think is important for us to be aware of, and you can attach additional pages as necessary.

Emergency Contact:

Name & Relationship _____

Phone # _____ Phone # _____

Name & Relationship _____

Phone # _____ Phone # _____

My son/daughter has permission to engage in the programs and activities at St. Ambrose University. In the event of an urgent medical matter, if I cannot be reached, I hereby give permission to the St. Ambrose University official and/or his/her designee to secure and authorize in my absence any and all medical treatment he/she deems necessary, including but not limited to Emergency Department treatment, laboratory tests, radiological tests/procedures, intravenous fluids, medications, physician services, and/or surgical procedures, for my child named above. In addition, I give my permission for the St. Ambrose University official and/or his/her designee to exchange information regarding my child's medical history and current medical/health status with the physician and medical facility staff.

X _____

Parent/guardian if participant under 18 years

X _____

Participant under 18 years

Print Name

Date: ____/____/____

Print Name

Date: ____/____/____