COE COLLEGE UPWARD BOUND PROJECT

STUDENT HEALTH INFORMATION AND MEDICAL TREATMENT FORM

Student's Name:_____________________________________ Birth date:_________________

Address:____

Home Phone Number:_______________________
Name of Parents, Guardian or Legal Custodians:_____________________________________

Parent's Employer__________________________ Phone:_____________________________

Parent's Employer__________________________ Phone:______________________________

Please indicate another person who would likely know where to reach you in case of an emergency.

Name:____________________________________ Phone:______________________________

Physician's Name___________________________Phone:______________________________

Student Health Information:
Any Chronic problem, illness or disability?____

Any medication now being taken?____

Any allergies to medications or local anesthetics?_______________________________________

Any other allergies?____

Other information that would be helpful to know?_____________________________________

Date of last tetanus shot? Month________________________ Year___________________

I authorize the physicians at St. Luke's Hospital, Mercy Care North or other hospitals and clinics to provide routine or emergency medical services for my son/daughter in the event that the need arises for the duration of their involvement in the Coe College Upward Bound Program.

Signature of Parent/Guardian (s)

____ Date:_____________________

____ Date:_____________________