TRiO UPWARD BOUND

UPWARD BOUND
The University of Virginia's College at Wise
STUDENT MEDICAL INFORMATION

UVA WISE

STUDENT INFORMATION

Name ____ SSN (last 4 only): XXX-XX-__ __ __ __
Last First Middle

Mailing Address ____ Telephone No. (____)____-______
Address City State Zip

Birthdate: ____/____/______ Gender: ❑M ❑F

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact

Name: ______________________________________ Relationship to student: ______________________

Home phone: (____)____-______ Mobile phone: (____)____-______ Work phone: (____)____-______

Secondary Emergency Contacts

Name:_________________________
Relationship:____________________
Home Phone: (____)____-______
Work Phone: (____)____-______
Mobile Phone: (____)____-______

Name:___________________________
Relationship:_______________________
Home Phone: (____)____-______
Work Phone: (____)____-______
Mobile Phone: (____)____-______

STUDENT HEALTH INFORMATION

Allergy Information

Does your child have any allergies? ❑NO ❑YES (If yes, please provide applicable detail below.)

❑Medications __________________________ ❑Insect venom _________________________
❑Foods ______________________________ ❑Pollen/dust/mold ______________________
❑Other ____

Does your child have any allergies for which they may require access to an EpiPen? ❑NO ❑YES*

*If your child has been prescribed an EpiPen, he/she is **required** to have it with them while at all UB events.

Has your child ever suffered a life-threatening allergic reaction? ❑NO ❑YES (If yes, please explain below.)

____

Health Conditions, Hospitalizations, & Vaccines

Does your child have any significant past or current health issues, hospitalizations, surgeries, or injuries? ❑NO ❑YES

If yes, please provide detail: ____
____

Has your child received any vaccines (i.e., tetanus, meningitis, chickenpox, etc.) within the past 5 years? ❑NO ❑YES

If yes, please provide detail: Vaccine: _______________ Date: __________
Vaccine: _______________ Date: __________

Does your child wear any of the following ? (check all that apply)

❑Eyeglasses ❑Contact lenses ❑Orthopedic aids ❑Hearing aids ❑Orthodontic aids ❑Other________________

Medications

Does your child currently take any medications? ❑NO ❑YES (If yes, please provide detail below.)

Medication: _____________________ Dosage/Frequency: _____________________ Reason: _______________
Medication: _____________________ Dosage/Frequency: _____________________ Reason: _______________

Limitations and Special Needs

Does your child have any condition that imposes physical limitations or requires special accommodations? ❑NO ❑YES

If yes, please provide detail: ____
____

OVER

STUDENT HEALTHCARE INFORMATION

Insurance Information

Please check the appropriate box and provide all applicable information:

❑ Student has no medical benefits coverage.

❑ Student is covered under Medicaid benefits.

Medicaid ID #: ____________________________

*****Please submit a copy of the front/back of your child's Medicaid card with this form.*****

❑ Student is covered under an employer-provided medical insurance plan.

Insurance company: Name: ___________________________________ Policy #: ____________________________

Address: _________________________________ Group #: ____________________________

City/St./Zip: _______________________________ Phone : (____) ____-_______

Policy holder info: Name: ___________________________________ Employer: ____________________________

*****Please submit a copy of the front/back of your child's insurance card with this form.*****

❑ Student is covered under an alternate type of medical benefits plan. (Please provide detail below).

____

*****Please submit a copy of the front/back of your child's medical benefits card with this form.*****

Provider Information

Primary physician name: ____

Name of facility: ___________________________________ Office phone: (____)____-______

Additional physician name (if applicable): ____

Name of facility: ___________________________________ Office phone: (____)____-______

PARENT/GUARDIAN DISCLOSURES AND ACKNOWLEDGEMENT

Over-the-Counter Medications

The UVa-Wise Upward Bound program maintains a supply of over-the-counter medications (e.g., pain relievers, fever reducers, anti-nauseants, cough suppressants, etc.) and first aid materials in the main office, summer residence halls, and on-hand when traveling with students. Upward Bound staff members will administer such items on an as-needed basis to students upon their request, unless otherwise instructed by their parent/guardian. Parents/guardians are encouraged to discuss any concerns related to this policy with the Upward Bound staff. Upward Bound does not have access to an EpiPen.

UVa-Wise Student Health Services

During the Upward Bound summer program and other activities during which the UVa-Wise Student Health Services are available, the Upward Bound staff may elect to accompany a student in need of non-emergency care to the health services office where a licensed medical professional can be consulted and provide treatment.

Accidents & Emergencies at Upward Bound

In case of an accident or emergency situation in which a student requires medical attention, the Upward Bound staff will immediately contact emergency medical personnel for assistance or transport the student to the nearest emergency room. Upward Bound will attempt to contact individuals listed as the student's emergency contacts.

Parent/Guardian Medical Release & Acknowledgment

My signature below indicates that I have read and acknowledge the following statements:

- In the event of a medical emergency involving my child, I hereby give permission for the administration of first aid by the UVa-Wise Upward Bound Staff or other qualified official, for treatment by an authorized physician, or for hospitalization. I release the UVa-Wise Upward Bound Staff and UVa-Wise from all liability for sickness, injury or accidents occurring during my child's participation in UVa-Wise Upward Bound activities.
- I understand that I will be contacted in the event that my immediate attention is required.
- I will inform the Upward Bound office of any changes to my child's medical information.
- I have read and understand the policies described in this section.

Parent/Guardian Signature: ____ ***Date:*** ____________________

Parent/Guardian Print Name: ____