INDIANA STATE UNIVERSITY

YOUTH PROGRAMS ON CAMPUS
STUDENT HEALTH INFORMATION FORM

YOUTH PROGRAM:

Name of Campus Program: _____

Dept/Organizer Contact Name: _____

Phone: _____ Email: _____

On-Campus Program Location(s) and Date(s): _____

_____

Description of Program: _____

_____

STUDENT INFORMATION:

Printed Name: _____ DOB: _____
Last First

Home Address: _____

City: _____ State: _____ Zip: _____

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: _____

Address: _____

Phone #: _____ Emergency Phone #: _____

HEALTH INSURANCE INFORMATION:

Company Name: _____ Policy #: _____ Group #: _____

Name of Policy Holder: _____

Student's Physician: _____

INDIANA STATE UNIVERSITY

YOUTH PROGRAMS ON CAMPUS
STUDENT HEALTH INFORMATION FORM

Please provide the information requested below, as it may be needed in case of an emergency.

Allergies: _____

_____

Conditions requiring special consideration (medical/physical): _____

_____

_____

Does your student require:

Epipen □ Yes □ No

Inhaler □ Yes □ No

Any medication currently taking (type of medication and time of administration):

_____

_____

_____

_____

Emergency Contact Information:

Primary contact name: _____

Relationship to student: _____

Cell Phone #: _____ Work Phone #: _____ Other: _____

Secondary contact name: _____

Relationship to student: _____

Cell Phone #: _____ Work Phone #: _____ Other: _____

TO ANY DOCTOR AND/OR HOSPITAL:
I hereby authorize the release of my child's pertinent medical information to the appropriate professional staff. I give permission to the physician or hospital to secure treatment for him/her and to order medications, injections, anesthesia, or surgery for my child, as named above, in case of emergency. The signature below constitutes authorization to perform any necessary treatment for my child.

Parent/Guardian Signature: _____

Department: _____ Rev: _____