



## Activity and Medical Release

**2007-2008**

(The following information is necessary to provide appropriate medical services.)

<b>STUDENT INFORMATION</b>	<b>NAME</b> (Last, First, Middle): _____ <b>SSN:</b> _____ <b>DATE OF BIRTH:</b> _____ <b>GENDER:</b> (circle one) Female or Male <b>AGE:</b> _____ <b>PERMANENT HOME ADDRESS:</b> <b>TELEPHONE NUMBER:</b> (____) _____ Number and Street: _____ City, State, Zip Code: _____
<b>PERSONAL MEDICAL HISTORY</b>	<b>HAVE YOU EVER BEEN DIAGNOSED BY A MEDICAL DOCTOR OR COUNSELOR WITH ANY OF THE FOLLOWING CONDITIONS?</b> (mark X) <input type="checkbox"/> Alcohol/Drug <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Hayfever <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Female Problems <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Pneumonia <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Thyroid Trouble <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Emotional/Behavioral Disorders  <b>SURGERY:</b> Please list any surgeries you have had. _____
<b>DISABILITIES</b>	<b>DO YOU HAVE ANY OF THE FOLLOWING DISABILITIES?</b> (mark X) <input type="checkbox"/> Amputation or Permanent Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Speech or Voice Impairment <input type="checkbox"/> Vision. If so, is it corrected? _____ <input type="checkbox"/> Permanently confined to wheelchair <input type="checkbox"/> Learning Disabilities. Specify _____ <input type="checkbox"/> Other Impairments. Specify _____
<b>ALLERGIES</b>	<b>ARE YOU ALLERGIC TO ANY SERUM, DRUG OR MEDICINE</b> (penicillin, antitoxin, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____ <b>DO YOU HAVE ANY OTHER ALLERGIES?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____
<b>MEDICATIONS</b>	<b>ARE YOU TAKING ANY MAINTENANCE MEDICATIONS OR ARE YOU CURRENTLY RECEIVING OTHER MEDICAL TREATMENT?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____
<b>IN CASE OF EMERGENCY</b>	<b>PARENT'S OR GUARDIAN'S INFORMATION</b> Name: _____ Home telephone number: _____ Work telephone number: _____ Place of work: _____  <b>EMERGENCY CONTACT</b> (In case parent or guardian cannot be reached) Name: _____ Telephone number: _____ Relation to you: _____
<b>FAMILY PHYSICIAN</b>	<b>DOCTOR'S NAME:</b> _____ <b>TELEPHONE:</b> _____ <b>ADDRESS:</b> _____ <b>PREFERRED EMERGENCY CENTER:</b> _____
<b>HEALTH INSURANCE</b>	<b>NAME OF INSURANCE COMPANY OR COUNTY PROVIDING MEDICAL ASSISTANCE:</b> _____ Policy Number: _____ Expiration Date (if any): _____

I hereby give my permission for my child, \_\_\_\_\_ to participate in all Portland State University, Upward Bound activities, trips, and events. I further give my permission for my child to receive all necessary medical and/or psychological attention if the need arises; such need shall be at the discretion of the medical provider on duty and/or the Upward Bound employee supervising or coordinating the activity, trip, or event.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date