

UPWARD BOUND HEALTH RECORD - A TRIO PROGRAM
The College of St. Scholastica

To be completed by student and parents. Please use ink and print clearly.

All information is confidential and used by the Upward Bound staff only.

Student's Name: _____
(Last) (First) (Middle)

Date of Birth: _____ High School: _____ Sex: Male Female

Home Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Social Security #: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party's
Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

MEDICAL & INSURANCE INFORMATION

Physician's Name: _____

Clinic _____ Phone (____) _____

Dentist's
Name: _____

Clinic _____ Phone (____) _____

Name of Insurance
Company: _____

Policy#: _____ Group#: _____

Must provide copy of both sides of Medical Card

In Case of Emergency, Notify:

1. _____ Relationship _____
Home phone (____) _____ Work phone (____) _____

2. _____ Relationship _____
Home phone (____) _____ Work phone (____) _____

I hereby authorize the Upward Bound Program at The College of St. Scholastica to communicate any health information they deem important for my son/daughter(s) health and welfare to members of the College personnel staff, or College faculty participating in the Upward Bound Program. I also request that _____ (student's name) be given any medical treatment necessary in the event of an emergency.

Parent/Guardian Signature

Date

(Please turn over)

HEALTH HISTORY
(Check and give approximate dates)

Ear Infections	_____	Rheumatic Fever	_____
Convulsions	_____	Diabetes	_____
Fainting Spells	_____	Blood Disorders	_____
Asthma	_____	Hives	_____

ALLERGIES

Hay Fever	_____	Food	_____
Poison Ivy	_____	Bee Stings	_____
Penicillin	_____	Other	_____

DISEASES

Chicken Pox	_____	Measles	_____
German Measles	_____	Mumps	_____
Heart Trouble	_____	Other	_____

Have you ever received counseling? Yes [] No []

If yes when and where? _____

Regular medications _____

Recent exposure to communicable disease _____

Operations or serious injuries _____

Chronic or recurring illnesses _____

Other diseases or details from above _____

IMMUNIZATION HISTORY
(Record Month/Year)

DPT series _____ Booster _____ Tetanus booster _____

Polio OPV (SABIN) series _____ Booster _____

Measles _____

Mumps _____

Rubella _____

Tuberculin skin test _____

RESTRICTIONS AT CAMP

Diet _____

Strenuous activity _____

Can you swim? _____