

Medical Emergency Form

The following information must be received before a student can participate in the HEOP Summer Institute Program. St. John Fisher College does not provide health and accident insurance for Summer Institute participants.

Parent/Guardian Data:

Student's Full Name: _____

Home Phone: _____

Parent/Guardian Name: _____

Cell: _____

Parent/Guardian Daytime Phone: _____

Evening Phone: _____

Emergency Contacts *(Please print clearly)*

1. _____ (_____) _____
 Name Relationship Phone

2. _____ (_____) _____
 Name Relationship Phone

My child is NOT currently taking any medication.

My child is currently taking the following medication(s) (You MUST include Dr.'s confirmation of prescription medication):

Name of Medication	Dosage (e.g. 2 times/day)	Time/Refrigeration required?
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1. _____	_____	_____
_____	_____	_____

Child can administer injections OR Child needs assistance with injections

Medical Background

Please check below any information about the medical history of your child that will help us to be prepared for his/her individual needs.

My child has a history of the following conditions and will be bringing medication to the program:

ASTHMA ALLERGIES to: ___ Poison Ivy ___ Pollen ___ Trees ___ Dust ___ Molds Migraine Headaches

Insects: _____ Medication: _____

Food Items: _____ Heart Condition – Please describe: _____

Diabetes – Medications/Dosage/Frequency: _____

Epilepsy – Medications/Dosage/Frequency: _____

Any limitations to activities: _____

Other health related concerns: _____

Insurance Policy Information *(For use strictly in the event of a medical emergency)*

Company Name: _____ Policy Number: _____

Policy Holder's Name: _____ Telephone Number: _____

Authorization for Emergency Medical Care

I give my child, _____, permission to participate in the HEOP Summer Institute program at St. John Fisher College. I agree that any injuries incurred will be covered on my own insurance coverage. I understand that in the event of an emergency, all efforts to contact me or my emergency contact numbers will be attempted by the HEOP staff. In order to meet legal requirements, I hereby authorize representatives of HEOP to give consent for any and all necessary emergency medical care for my child, named above, while said child is participating in the program.

Parent/Guardian Name (Please Print): _____

Signature of Parent/Guardian: _____

Date: _____

Please return form to:

Tara Preteroti • Academic Opportunity Programs Office, L-105 • 3690 East Avenue • Rochester, NY 14618