MEDICAL TREATMENT AUTHORIZATION

All minors who are involved in University-sponsored programs, programs held at the University and/or programs housed in University facilities, are required to have their parent/guardian complete this document and return it to the University. The information on this document will be shared on a need to know basis only, and will otherwise be kept confidential.

Name______________________________ Date of Birth____/____/____ Gender___ E-Mail_____________

Address____________________________ City_________________ State_____ Zip_______________

Mother_____________________________ Father______________________ Guardian____________________

Home Phone________________________ Home Phone_________________ Home Phone_________________

Work Phone_________________________ Work Phone_________________ Work Phone_________________

Cell Phone__________________________ Cell Phone__________________ Cell Phone__________________

List the following information for the person who carries medical insurance on the participant:

*******Please provide a copy of the insurance card*******

Full Name___________________________ Employer__________________________

Address____________________________ City_________________ State_____ Zip Code_________

Insurance Co.________________________ ID, Group & Plan Nos. ______________________________

*******Please provide a copy of the insurance card*******

MEDICAL HISTORY OF PARTICIPANT

CURRENTLY HAS (OR HAS EVER HAD)	NO	YES
1. ALLERGIES TO FOODS	___	___ SPECIFY____________________________
2. ALLERGIES TO MEDICATIONS	___	___ SPECIFY____________________________
3. ENVIRONMENTAL ALLERGIES	___	___ SPECIFY____________________________
4. ASTHMA (OR OTHER RESPIRATORY ILLNESS)	___	___ SPECIFY____________________________
5. DIABETES	___	___ SPECIFY____________________________
6. SEIZURE/EPILEPSY	___	___ SPECIFY____________________________
7. HEART OR BLOOD PRESSURE CONDITION	___	___ SPECIFY____________________________
8. ORTHOPEDIC ISSUES REQUIRING MEDICAL ATTENTION	___	___ SPECIFY____________________________
9. ANY CONDITION LIMITING STRENUOUS ACTIVITY	___	___ SPECIFY____________________________
10. SERIOUS ILLNESS/INJURY REQUIRING HOSPITALIZATION	___	___ SPECIFY____________________________
11. ATTENTION DEFICIT DISORDER (ADD) or AD/HD*	___	___ SPECIFY____________________________
12. A PSYCHIATRIC DIAGNOSIS (such as depression, OCD, panic/anxiety disorder, eating disorder)*	___	___ SPECIFY____________________________
13. EMOTIONAL HEALTH CONCERN*	___	___ SPECIFY____________________________
14. SEEN OR IS CURRENTLY SEEING A PROFESSIONAL TO ADDRESS MENTAL/EMOTIONAL CONCERNS*	___	___ SPECIFY____________________________

*If you answered “yes” to statements 11-14 above, please attach a separate sheet providing details.

ANY OTHER HEALTH RELATED ISSUE(S): SPECIFY____

DAILY MEDICATIONS (NAME, DOSAGE, TIMES, CONDITION MEDICATION TREATS)
SPECIFY____

AS NEEDED MEDICATIONS (NAME, DOSAGE, FREQUENCY, CONDITION MEDICATION TREATS)
SPECIFY____

Is this person normally aware of his/her own health care needs? Yes_____ No_____

Additional Information: Please provide in the space below any additional information about the participant's health that you think is important for us to be aware of, and you can attach additional pages as necessary.

____
____
____
____
____
____
____
____
____
____

Emergency Contact:

Name & Relationship ____
Phone # ____________________________ Phone # __________________________________
Name & Relationship ____
Phone # ____________________________ Phone # __________________________________

My son/daughter has permission to engage in the programs and activities at St. Ambrose University. In the event of an urgent medical matter, if I cannot be reached, I hereby give permission to the St. Ambrose University official and/or his/her designee to secure and authorize in my absence any and all medical treatment he/she deems necessary, including but not limited to Emergency Department treatment, laboratory tests, radiological tests/procedures, intravenous fluids, medications, physician services, and/or surgical procedures, for my child named above. In addition, I give my permission for the St. Ambrose University official and/or his/her designee to exchange information regarding my child's medical history and current medical/health status with the physician and medical facility staff.

X______________________________________
Parent/guardian if participant under 18 years

____
Print Name

Date: ____/____/______

X______________________________
Participant under 18 years

____
Print Name

Date: ____/____/______