

**UNIVERSITY OF VERMONT**  
**UPWARD BOUND MEDICAL FORM**

Please complete, sign, and **MAIL** this original form to:

**UVM Upward Bound Program**, 227 Commons Living & Learning, 633 Main Street, Burlington, VT 05405  
Phone: (802) 656-2961, Fax: (802) 656-0055

<b>PART 1: TO BE COMPLETED BY PARENT/CUSTODIAL GUARDIAN</b>		
Name:	Birthdate:	Social Security #:     /     /
Address:	City/State:	Zip:
Home Phone: (     )	Cell Phone (if applicable): (     )	
Weekend Phone: (     )	Beeper number (if applicable): (     )	
Fathers Name:	Business Phone: (     )	
Mother's Name:	Business Phone: (     )	
Emergency Contact Name:	Phone: (     )	
Emergency Contact Name:	Phone: (     )	

<b>PART 2: FAMILY HEALTH INSURANCE INFORMATION</b>		
Carrier:	Group #:	Policy #:
Relationship to participant:	Social Security number of policy holder or ID number:	

<b>PART 3: TO BE SIGNED BY PARENT/GUARDIAN</b> <i>(must be signed for attendance in program)</i>
<p>I understand that I am responsible for any additional medical costs and related costs (medications, hospital bills, doctor visits, additional transportation and accommodations, etc.) for my child. I hereby give permission to the medical personnel selected by the Upward Bound Program and its representatives, including but not limited to the University of Vermont Center for Health &amp; Wellbeing and Fletcher Allen Hospital to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Upward Bound Programs to secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child as named above. The representatives of UVM Upward Bound Program have my express permission to act in the place and instead of, and with the same authority as the parents on behalf of my child throughout the duration of the program. This completed form may be photocopied. <b>My signature affirms the information on this form is factually correct.</b></p>
<p>PARENT/GUARDIAN SIGNATURE: _____ DATE: _____</p>

<b>PART 4: HEALTH HISTORY TO BE COMPLETED BY PARENTS</b>
<b>MEDICATIONS BEING TAKEN</b> - please list all medications currently being taken, including non-prescription medications.
€ This person is currently taking <b>NO</b> medications on a routine basis.
€ This person is taking the following medications - <b>Please attach additional necessary information on medications.</b>
Medication #1: _____ Dosage: _____
Reason for taking medication: _____
Medication #2: _____ Dosage: _____
Reason for taking medication: _____
Identify any medications taken during the school year that participant does/may not take during the summer:
Medication #1: _____
Medication #2: _____
Medication #3: _____

NAME OF STUDENT: \_\_\_\_\_

Medication Allergies (List)		Food Allergies (List)	Other Allergies - Include Insect Stings, Asthma, Etc.
1			
2			
3			

DIETARY RESTRICTIONS: The following restrictions apply to this student:

- Does not eat red meat     
  Does not eat poultry     
  Does not eat dairy products  
 Other (describe):

ACTIVITY RESTRICTIONS: (e.g. what cannot be done, what adaptations or limitations are necessary)

**PART 5: TO BE COMPLETED AND SIGNED BY YOUR PHYSICIAN OR SCHOOL NURSE**

PHYSICAL EXAMINATION: I have examined the above Upward Bound participant. Date of the examination:

Blood pressure: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

In my opinion, the above applicant  IS  Is not able to participate in an active pre-college enrichment program.

The applicant is under the care of a physician for the following conditions:

1	
2	
3	

**DESCRIBE ANY LIMITATIONS OR RESTRICTION OF ACTIVITIES:**

1	
2	
3	

**GENERAL QUESTIONS (Explain "Yes" answers below)**

Has/does the participant:		YES	NO			YES	NO
1	Had any recent injury, illness or infectious disease?			15	Have any skin problems (e.g. itching, rash, acne)?		
2	Have a chronic or recurring illness/condition?			16	Have diabetes?		
3	Ever been hospitalized?			17	Have Asthma?		
4	Ever had surgery?			18	Had mononucleosis in the past 12 months?		
5	Have frequent headaches?			19	Had problems with diarrhea/constipation?		
6	Ever had a head injury:			20	Have problems with sleepwalking?		
7	Ever been knocked unconscious?			21	If female, have an abnormal menstrual history?		
8	Wear glasses, contact or protective eyewear?			22	Ever had an eating disorder?		
9	Ever passed out during or after exercise?			23	Ever taken any type of anti-depressant medication?		
10	Ever had high blood pressure?			24	Ever had chest pains during or after exercise?		
11	Ever diagnosed with a heart murmur?			25	Ever been dizzy after exercise?		
12	Ever had back problems?			26	Ever taken Ritalin for an Attention Deficit Disorder?		
13	Ever had emotional difficulties for which professional help was sought?			27	Ever been diagnosed with an Attention Deficit Disorder?		
14	Will student be taking Ritalin for an Attention Deficit Disorder this summer?						

Please explain any "yes" answers in detail (continue on additional sheet if necessary):

Which of the following has the participant had?

€ Measles		€ Chicken Pox		€ German Measles		Mumps		€ Hepatitis	
Immunizations		Completed Last Booster		Immunizations		Completed Last Booster			
1	Tetanus			7	MMR				
2	DPT				Measles				
3	TD (tetanus/diphtheria)				Mumps				
4	Polio				Rubella				
5	Varicella (chicken pox)			8	Hepatitis B				
6	TB Mantoux test	Date:	Result:	9	BCG				

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the pre-college program should be aware:

The above person is in satisfactory health and may engage in all usual activities except as noted:

**Signature** of licensed medical personnel \_\_\_\_\_

**Printed name** \_\_\_\_\_

**Title** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** \_\_\_\_\_

**City** \_\_\_\_\_

**State** \_\_\_\_\_

**Zip** \_\_\_\_\_

**Parent/Guardian Signature Required:**

I give permission for my child (print name) \_\_\_\_\_ to receive over-the-counter medicines (e.g., aspirin, Tylenol, antacids) if needed.

\_\_\_\_\_  
Print name of parent/guardian

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date