

CONFIDENTIAL

MEDICAL INFORMATION

College of Saint Benedict/Saint John's University
UPWARD BOUND Program

Student Name

Completion of the authorization for treatment of minor, medical coverage and/or insurance information, medical history and immunization records is necessary for all UPWARD BOUND participants so that we can make informed decisions about your child's care. This information is kept on file at the College of Saint Benedict/Saint John's University UPWARD BOUND Program.

AUTHORIZATION FOR TREATMENT OF A MINOR

I extend the following authorization to the UPWARD BOUND Program staff with regard to my daughter/son: _____

- 1. Permission to any doctor or health vendor to render emergency and/or routine medical care as needed for the above-named child. I understand that every attempt will be made to notify me in case of serious illness or emergency.*
- 2. Permission to any doctor or health vendor to make inquiry regarding the past medical history, including physicians and/or hospital care for the above-mentioned child.*
- 3. I also give permission for my child to keep prescription and/or over-the-counter medication in his/her possession and to self-administer them without supervision.*

Name of Child's Physician

Address of Clinic

Clinic Affiliation of Physician

Telephone # of Clinic

Hospital Covered by Insurance

Location of Hospital

Please complete reverse side of sheet

Telephone # of Hospital

Parent/Guardian Signature

Date

Emergency Phone Number(s)

HOSPITAL and MEDICAL INSURANCE or OTHER COVERAGE

In order to assist the College of Saint Benedict/Saint John's University in obtaining assistance in the payment of expenses incurred for hospital and/or medical services for your daughter/son, it is most helpful if the Colleges know the name, address, and policy numbers of your insurance carrier.

1. Hospital or Medical Insurance

Name of Company _____ Policy Number _____

Name of Insured _____

2. Welfare Coverage

Location of Welfare Board _____

3. Public Health Service Facility

Name of Hospital or Clinic _____

Location _____

CONFIDENTIAL

IMMUNIZATION RECORD

College of Saint Benedict/Saint John's University
UPWARD BOUND Program

Student Name

Please have your school nurse or physicians' office complete this form and return to the address listed on the back of this sheet.

Students without proof of adequate immunization to Rubeola could be asked to leave school for up to four weeks in case of an outbreak. Proof of disease by office record, letter proving immunity or documentation of immunization is needed to comply with State Health Department requirements in case of an outbreak. If you have an official immunization record, please copy and attach.

IMMUNIZATION RECORD

<i>IMMUNIZATION</i>	<i>ORIGINAL IMMUNIZATION DATE</i>	<i>DATE OF BOOSTER</i>
Tetanus		
Diphtheria		
Polio		
MMR (measles, mumps, rubella)		
Rubeola		
Typhoid Fever		
Hepatitis B	Series dates: _____	

TUBERCULOSIS TEST RESULTS AND DATES

Chest X-Ray:	PPD:	Tine:
--------------	------	-------

Physician/Nurse Signature

Date

Return to:
UPWARD BOUND
College of Saint Benedict
37 S. College Ave
St. Joseph, MN 56374

Please complete reverse side of sheet

PERSONAL MEDICAL HISTORY

Student Name

Have you been hospitalized in the last three years? Yes No

If yes, explain: _____

Please list any medications you are currently taking:

Please list any allergies you have (i.e.: food, drug, etc.):

If you will need allergy shots while at the College of Saint Benedict, please contact the program Director to make arrangements.

Do you have now, or have you ever had, any of the following? Please check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Measles (reg, hard, red) | <input type="checkbox"/> Measles (German, 3 day) |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Poliomyelitis |
| <input type="checkbox"/> Hearing Impairments | <input type="checkbox"/> Visual Impairments |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Gall Bladder Disease |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Colitis or Colon Problems | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Hernia or Rupture | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Seasonal, Food or other Allergies |
| <input type="checkbox"/> Congenital Heart Problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Gynecological Problems |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Sickle Cell Trait or Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Headache (chronic or severe) |
| <input type="checkbox"/> Dizziness or Fainting Spells | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Chronic Skin Problems |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hypoglycemia |