Health Information and Delegation of Consent for Treatment – May Term

1. Student Information:

Student's Legal Name _____ Goes by _____

Address_____

City_____ State_____ Zip_____

Gender_____ Date of Birth_____ E-mail Address_____

Age_____ Grade _____

2. Parent/Guardian Information:

Parent/Guardian Name_____

Address (if different from student) _____

City_____ State_____ Zip_____

Landline Phone_____ Cell Phone_____

Work Phone_____ E-mail_____

Occupation/Employer_____

Other Parent/Guardian (if applicable) _____

Relationship_____ Best Phone for Contact_____

3. Emergency Contact Information:

This person will be contacted ONLY in case of an emergency and if the student's mail parent/guardian cannot be reached.

Emergency Contact Name_____ Relationship_____

Main Phone_____ Other Phone_____

4. Physician/Insurance Information

Does the student have health/medical insurance? **Yes** / **No** (please circle)

Company Name_____ Policy/Contact Number_____

Policy Holder's Name _____ Relationship _____

Primary Physician_____ Phone_____

Dentist's Name _____ Phone_____

5. Medical Conditions/Allergies

Please list any known conditions

Allergies (food, medications etc.) Reactions	Special Medical Conditions

The parent/guardian is responsible for all medical fees incurred while in attendance at the May Term Internship location. I/we being the parent(s) or legal guardian(s) of the above named student do herby delegate to Dr. Joel Olufowote of the Indiana Academy the authority to consent to all health care (including but not limited to diagnostic tests, x-rays, physical examinations, routine medical tests, injection, hospitalization, anesthesia procedures, surgery, toxicology screens and blood tests for communicable conditions) to be rendered to the above named student for the duration of his/her participation in the Indiana Academy's May Term Internship Program.

Parent/Guardian Signature (required) Date

Witness Signature (required) Date