

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 fo	r Contact	
3. Emergency Contact Information: <i>This person will be contacted ONLY in ca</i>	se of an emergency a	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)

Witness Signature (required)

Date

Date