



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 hereby 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

Student Signature (required)

Date