UNIVERSITY OF ILLINOIS
AT URBANA-CHAMPAIGN

TRIO Academic Talent Search College Prep Program
130 Turner Student Services Building
610 East John Street
Champaign, IL 61820

EMERGENCY MEDICAL FORMS

PROGRAM NAME: **TRIO Academic Talent Search College Prep Program**

PROGRAM CONTACT PERSON(S): **Courtney Valentine / Curtis Blanden**

(PLEASE PRINT)

Participant Name: _____
Last First Middle Name

Hospital Preference: _____

Address: _____
Street City State Zip Code

Social Security Number (Last Four)_____ Age:_____ Sex: Male☐Female☐ Date of Birth:_____

PARENT/GUARDIAN & OTHER EMERGENCY CONTACTS

Parent/Guardian Information

Name:_____ E-Mail:_____
Relationship to Student

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Address: _____
Street City State Zip Code

Emergency Contact

Name:_____ E-Mail:_____
Relationship to Student

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Address: _____
Street City State Zip Code

HEALTH INFORMATION STATEMENT

Please write or circle below any information you feel the staff may need to maximize the safety and the well-being of your child. To the right of the condition statement is space for more information relating to the condition. Please be specific. In case of an emergency, this health information may be the only source of accurate important information.

If your child does not experience any of the conditions below please write **N/A** on the space provided. **Please provide answers to all questions listed.** This information is CONFIDENTIAL.

Nervous or Mental (epilepsy, emotional stress, convulsion)
_____

Lung Disease (asthma, persistent cough, tuberculosis) _____

Disease of Heart or Blood Vessels, Increased or Abnormal Blood Pressure_____

Pain in Chest or Shortness of Breath (heart murmur, rheumatic fever) _____

Stomach or Intestinal Trouble (ulcers, gall bladder, or liver disorder, jaundice, hernia, colitis)
_____

Arthritis, Diabetes, Kidney or Bladder Disease (Please circle one) YES NO

Hay Fever or Allergies (Please circle one) YES NO SEASONAL

Impaired Sight or Hearing, Chronic Ear Infections (Please circle one) YES NO SOMETIMES

Recent Surgical Operations, Accidents or Injuries _____

Any Infectious Diseases_____

Skin Disease_____

Allergy to Foods (please list) _____

Significant Orthopedic and/or Neuromuscular Impairment (i.e. loss of limb, spinal cord injury) YES NO

Does your child wear Glasses? YES NO SOMETIMES

Does your child wear Contacts? YES NO SOMETIMES

Date of last TETANUS BOOSTER_____

Below list any personal problems that your child experiences; (i.e. medical, dental, psychological, behavioral, etc.) Please indicate any medication your child takes and any pre-existing illnesses which may limit or restrict his/her activity. Confidential matters may be communicated to the Academic Talent Search College Prep Program director by separate correspondence. If your child does not experience any of the conditions below please write **N/A** on the space provided. **Please do not leave any questions unanswered.**

List prescribed medications and its purpose:

Prescribed Medication	Purpose of Medication

Allergic Reaction to Medications (including penicillin, tetanus) _____

Current Medication(s) (list names and doses)

Name of Medication	Dosage

Medication that needs Refrigeration (Please circle one): ☐ YES ☐ NO
If yes please list medication _____

*If your student is receiving the on-going care of a Physician, please provide the doctor's name and phone number. Name: _____ Phone: _____

(PLEASE COMPLETE SECTION BELOW)

Family Doctor's Name:_____ Clinic/Hospital: _____

City, State:_____ Phone Number: _____

Health Insurance Provider Name: _____
Health Insurance Policy Number:
_____

Public Assistance Green Card #: _____

The TRIO Academic Talent Search College Prep Program employees (staff) of the University of Illinois at Urbana-Champaign campus **WILL NOT** dispense over-the-counter (OTC) or prescription medication to participants. Participants will be allowed to possess and take OTC medication on their own if such permission is granted by the parent or guardian on the mandatory Parent/Guardian Permission Statement Form.

Participants will be allowed to take prescribed medication on their own if:
(1) The medication is in a clearly marked prescription container, and
(2) The medication is accurately and completely noted on the Emergency Medical Information form.

*All authorized OTC or prescription medications should be listed on this form and in proper travel container.