University of La Verne

MEDICAL HISTORY AND EMERGENCY MEDICAL RELEASE FORM

This information is gathered to assist in identifying appropriate care for you. All medical information is confidential. This form must be completed by any adult volunteer, independent contractor or program participant. Keep a copy of the completed form for your records. Any changes to this form should be provided to the Program Director prior to your involvement in any University of La Verne program. Please make sure that that you provide detailed and accurate information so that the staff members are aware of your needs.

Name: _____

Home Address: _____

Phone:_____Date of Birth_____

List TWO emergency contacts:

Name: _____Relationship: _____

Phone:_____

Name: _____Relationship: _____

Phone:_____

Do you have any physical limitations that will restrict participation in program activities? ❑ Yes ❑ No

If Yes, please explain: _____

Have you been injured and needed medical treatment within the last year? ❑ Yes ❑ No

If Yes, please explain: _____

Are you presently undergoing professional counseling or therapy? ❑ Yes ❑ No

If Yes, please explain: _____

Allergies

Allergies to Medication

List all known: _____

Describe reaction and management to the reaction: _____

_____

_____

Allergies to Food

List all known: _____

Describe reaction and management to the reaction: _____

_____

_____

Other Allergies — include stings, hay fever, asthma, animal dander, etc.

List all known: _____

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Describe reaction and management to the reaction: _____

_____

_____

MEDICAL HISTORY AND EMERGENCY MEDICAL RELEASE FORM CONTINUED

Medications

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire duration of the program. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Do you take medications on a routine basis? ❒ Yes ❒ No

Will you be taking any prescribed medication during the program? ❒ Yes ❒ No

If YES please provide the following information: (Attach additional pages for more medications.)

Med #1:_____ Dosage: _____
Specific times taken each day: _____
Reason for taking: _____

Med #2:_____ Dosage: _____
Specific times taken each day: _____
Reason for taking: _____

Do you have any of the following medical conditions? (Check all that apply)

❒ Asthma ❒ Allergies ❒ Convulsive Disorders ❒ HIV Positive
❒ Heart Problem ❒ Pulmonary Disorders ❒ Muscular-Skeletal Disorder
❒ Diabetes ❒ Mellitus ❒ Hepatitis ❒ Oitus Media
❒ Skin Infection ❒ Neurological Disorder ❒ Epilepsy
❒ Other issues the medical staff should be aware of? (Please elaborate)

_____

Dietary Restrictions

Please check all restrictions that apply to this individual.

❒ Does not eat red meat ❒ Does not eat pork ❒ Does not eat eggs
❒ Does not eat poultry ❒ Does not eat seafood ❒ Does not eat dairy products
❒ Other (If other, please use the space below or separate sheet to explain)

*Food cannot always be prepared to order in each of our programs, however University of La Verne will exert significant effort to be inclusive in our food offerings.

_____

Emergency Medical Release

In the event of an accident or illness requiring emergency medical care, I give permission to the University of La Verne and/or the attending certified medical staff to order such medical attention as may be deemed necessary for my health and safety. I have provided phone numbers and other pertinent information for the staff to use in case of an emergency.

The medical information provided above is complete and accurate to the best of my knowledge.

Agreement to Abide by Restrictions

I, _____, understand and agree to abide by the restrictions placed on my activities during this program.

Signature: _____ Date: _____

(Participant Signature)