STUDENT MEDICAL FORM (REQUIRED)

College of Fine + Applied Arts
University of Illinois at Urbana-Champaign

Please note: This form must be received at least 2 weeks prior to program.

PRINT or TYPE

STUDENT

Student Name: _____
Student Age: _____ Gender: _____ (M or F or Trans) Birth Date: _____
Student Home Phone Number: (_____) _____
Student Cell Phone Number: (_____) _____

PAYMENT INFORMATION - Parent or Guardian Responsible for Payment:

Last Name: _____ First Name: _____ M. Int. _____
Relationship to student: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: (_____) _____
Work Phone Number: (_____) _____
Cell Phone Number: (_____) _____

EMERGENCY AUTHORIZATION - In an emergency, if parent/guardian cannot be reached, I authorize Carle Clinic, Carle Hospital, or other health care providers to administer medical care as required:
Signature of Parent or Guardian: _____ Date: _____

EMERGENCY CONTACT - In an emergency, if parent/guardian cannot be reached the following person will be contacted:

Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: (_____) _____
Emergency Cell Phone Number: (_____) _____

INSURANCE COMPANY/FAMILY PHYSICIAN - Insurance and Healthcare Provider

Name of Insurance Company: _____
Phone Number: (_____) _____
Policy Number: _____ Group Number: _____
Phone Number: (_____) _____

Family Physician: _____
Phone Number: (_____) _____

STUDENT MEDICAL HISTORY - Check the box before any of the following diseases the student has had. Write at what age the student had the disease in the space provided.

□ Chicken Pox _____ □ Hay Fever _____ □ Mumps _____

□ Lung Disease _____ □ Heart Disease _____ □ Poliomyelitis _____

□ Diabetes _____ □ Hernia (rupture) _____ □ Scarlet Fever _____

□ Diphtheria _____ □ Measles _____ □ Smallpox _____

□ Whooping Cough _____ □ Measles (3-day) _____ □ Typhoid Fever _____

□ Allergies (specify)

_____

□ Asthma _____ □ Nervous or Mental (epilepsy, emotional stress, convulsion _____

FOOD ALLERGY - If yes, you will receive additional information.

Yes □ No □

IMMUNIZATIONS – Date, Booster

Measles: _____ Diphtheria: _____ Whooping Cough: _____

Tetanus: _____ Polio: First _____ Second _____Third _____

Smallpox: _____ Flu: _____ Rubella: _____ Typhoid: _____

Mumps: _____ Pneumonia: _____ Last TB Test: _____

Chickenpox: _____ Other:

_____

MEDICATION INFORMATION/STUDENT HEALTHCARE MONITORING

List all medications taken regularly and specify the need for such medication:

_____

_____

List medications taken only as needed:

_____

_____

Is student allergic to any medications?

_____

Is student capable of reasonable physical activity (athletics, strenuous activity)?

Yes □ No □

If no, state reason and limitations:

_____

_____

_____

If student attends program, should the student be monitored by health care provider?

Yes □ No □

If yes, specify reason and suggested healthcare provider (if applicable):

_____