



# MASC/MAHS Summer Leadership Camp

## Student Medical Information Form



Please Print or Type Information in Blue or Black Ink

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Phone #s: \_\_\_\_\_

Additional Emergency Contact:

Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone(s) \_\_\_\_\_

### SCHOOL INFORMATION

School Name: \_\_\_\_\_

Principal: \_\_\_\_\_ Phone: \_\_\_\_\_

Adviser: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION

Payment Type for Medical Treatment

\_\_\_\_ Private Insurance

\_\_\_\_ Personal Pay

Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Type: PPO HMO Medicaid Other: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\*\*SEE BACK SIDE FOR ADDITIONAL REQUIRED INFORMATION\*\*\***

I, the parent or legal guardian of \_\_\_\_\_ (my child), authorize the Michigan Association of Student Councils and Honor Societies to obtain emergency medical care for my child in the event such care is necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment for such care. I release MASSP, MASC/MAHS, its employees, volunteers, and agents from any damages, liability, or loss resulting from their securing in good faith medical care for my child.

Signed: \_\_\_\_\_ (DATE) \_\_\_\_\_

PRINT NAME \_\_\_\_\_ (Parent or guardian)



MASC/MAHS Summer Leadership Camp  
Albion College, Albion, MI



**MEDICAL INFORMATION AND MEDICAL HISTORY**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Past Medical History (i.e. surgeries, hospitalizations, injuries):  
Please only disclose information you are comfortable sharing that may be currently relevant!

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medical Conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: (current and last 30 days)

Medication Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medications, Foods, Items:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any over-the-counter medications that should NOT be administered?

Yes (explain) No

\_\_\_\_\_  
\_\_\_\_\_

The licensed health care staff and camp administrative staff can provide my child with these medications if necessary:

Tylenol    Motrin/Advil    Tums/Antacid    Benadryl    Aspirin

No medication should be administered to my student