MEDICAL FORM

MEDICAL HISTORY, TREATMENT PERMISSION AND RELEASE NOTE: This form is required prior to participation in the Step-Up Program for High School Students. Participation will not be permitted until this form has been completed and signed and is on file.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Father/Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (h) _____ (w) _____ (c) _____

Mother/Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (h) _____ (w) _____ (c) _____

Other/Emergency Contact

Name: _____

Phone: (h) _____ (w) _____ (c)_____

Family Physician:

Name: _____ Phone: _____

Is the participant under the care of a medical provider for a medical and/or psychological problem?

NO YES _____

Does a health care provider prescribe the participant medication?

NO YES _____

If yes, does the STEP-UP participant need reminders to take his/her medication?

NO YES _____

Any side effects or anything else we should know about this medication?

NO YES _____

Does the participant have any allergies?

NO YES _____

If yes, please list the allergy and provide additional information if necessary.

Allergies:	NO	YES _____
Insect bites/stings	NO	YES _____
Medications	NO	YES _____
Food	NO	YES _____

RELEASE OF LIABILITY: I hereby release and discharge, indemnify and hold harmless the NIH/NIDDK STEP-UP PROGRAM, and their members officers, agents, employees, and any other persons or entities acting on the behalf, and the successors and assigns for any and all of the aforementioned persons and entities, against all claims, demands, cost and expenses, and causes of action whatsoever, either in law or equity, arising out of or in any way connected with any property loss and/or bodily injury and/or disability, arising from my child's participation in the summer program, including overnight stays during the Symposium.

CONSENT FOR TREATMENT: I hereby give my permission to provide on-site first aid for minor injuries. In the event of injury such as broken limb, sprain, contusion, laceration, concussion, etc., or illness requiring medical diagnosis or treatment, I hereby give my consent for the staff to secure the proper medical care, including transportation and hospitalization, if necessary. Every attempt will be made to contact the parent or guardian to inform you of the need for any medical attention beyond minor first aid, if necessary.

NOTE: Overnight stays; transportation and all other activities will be supervised by chaperones.

PHYSICAL EXAMINATION WITHIN ONE YEAR: I certify that within the past 12 months my child has had a physical examination by a physician.

ASSUMPTION OF FINANCIAL RESPONSIBILITY: I hereby acknowledge that I am responsible for medical charges incurred during the internship participation.

Print name: _____ Date: _____

Signature: _____

Relationship to Participant: _____

STUDENT Name: _____

I understand the NIH/NIDDK STEP-UP PROGRAM is not responsible for accidents occurring at the Symposium or during transportation of students resulting in medical, dental, or other expenses including the loss of personal items.

Parent/Guardian Signature: _____ Date: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____