NOTE: This is an example form. You must modify it to reflect your specific program and activities. The legal language has been approved by General Counsel and should not be altered.

HEALTH AND EMERGENCY INFORMATION FORM
UNIVERSITY OF SOUTH CAROLINA

(Please print or type)

Program: _____ **Date(s):** _____

Participant's Full Name: _____

Date of Birth: _____ **Grade:** _____

Home Address: _____
Street Unit Number

_____ **Phone** _____
City State Zip

Blood Type: _____

Health/Special Needs Information (Attach additional sheets as necessary to fully respond to the following questions.)

1. Do you have any allergies that we should know about prior to emergency treatment?

_____

2. Do you have any chronic conditions/illness that we should know about prior to emergency treatment?

_____

_____

3. Do you have any disability/special needs (visual, hearing, physical, psychological, unable to climb stairs without assistance) which requires special attention or special accommodation? If yes, please explain.

_____

Medications

1. Please list any medications you are currently taking.

Prescription *Dosage* *Doctor* *Special Instructions*

_____

_____

_____

Medical Authorization

The University of South Carolina is also authorized to provide or to arrange for any medical treatment my child may need during the course of this program. I understand and agree to be responsible for any and all costs associated with such services.

1. In such an event of illness or injury, I wish to be contacted at the following telephone numbers:

Home: ( ) _____ Work: ( ) _____ Mobile: ( ) _____ Other: ( ) _____

2. In addition to authorizing medical care, I hereby certify that any charges related to the medical care given to my child will be borne by me. The insurance company and policy information that covers my child is as follows:

_____

Insurance Carrier Policy Holder Policy Number

I understand the medication prescribed by my Physician will be kept in a locked box by the staff while I am participating in the program. It is my responsibility to obtain the medication from the staff and take the medication as directed by the Physician.

_____ _____ _____ _____

Parent/Guardian Signature (required) Date Participant Signature Date

Revision Date: 4/17/24