SUMMER SURGERY PROGRAM
UC IRVINE SCHOOL OF MEDICINE

Phone: 714.456.3429 E-mail: summersurgery@uci.edu

STUDENT HEALTH HISTORY/MEDICAL PERMISSION FORM

Student Last Name: _____ First Name: _____Middle Initial: ___

Address: _____ Home Phone: _____

Health Insurance Provider: _____ Policy Number: _____

Name of Primary Policy Holder: _____

List all prescription medications student is currently or may be taking:

Name: _____ Dosage: _____ Frequency: _____ Reason: _____

Name: _____ Dosage: _____ Frequency: _____ Reason: _____

Name: _____ Dosage: _____ Frequency: _____ Reason: _____

List student's known food, drug, animal or environmental allergies: _____

_____

List any other medical conditions for which the student is being treated: _____

_____

Physician Name: _____ Physician Phone: _____

Initial to be called before any over-the-counter medication is dispensed: _____

A copy of the student's immunization record is required. In addition, proof is required of:

- Hepatitis B vaccine (proof of three doses)
- Tdap vaccination for diphtheria, tetanus and pertussis (whooping cough) within last three years
- Tuberculosis skin test within the last year

- Varicella (chickenpox) vaccine or blood test to prove immunity

Please skip to the signature line if you are age 18 or older.

I certify that this health history information is correct and complete. The student herein described has my permission to engage in all camp activities except as noted here: _____

_____

I, the parent/guardian of _____, hereby authorize the UC Irvine Summer Surgery Program to provide routine healthcare, administer prescribed medications and seek emergency medical treatment, including X-rays or routine tests. I give permission to the physician chosen by the program to secure and administer treatment for the named student, including emergency medical or surgical treatment and hospitalization.

I am financially responsible for any medical attention needed or resulting from any injury received during the session. My medical insurance shall be the insurance coverage for any medical treatment. This form may be photocopied for trips outside the general lab facilities.

I hereby release, indemnify and hold harmless UC Irvine and its Summer Surgery Program, its trustees, employees, volunteer workers, students, agents and assigns from any and all liability, damage and claim of any nature whatsoever arising from or in any way related to my/my child's participation in the Summer Surgery Program. Participating in any activity is an acceptance of some risk of injury. I agree that my/my child's safety is primarily dependent upon taking proper care of himself/herself. Despite precautions, accidents and injuries may occur and injury and/or loss or damage to personal property may occur as a result of participating in the Summer Surgery Program; therefore, I assume all risks related to participating in the Summer Surgery Program. I also hereby acknowledge that the UC Irvine Summer Surgery Program, its trustees, employees, volunteer workers, students, agents and assigns assume no liability whatsoever for personal injuries or property damage that may arise from my/my child's participation in the program.

My signature on this form indicates that I have read, understood and freely signed this agreement.

Student Name (Print Legibly) _____

Student Signature _____

Parent/Guardian Name (Print legibly): _____

Signature: _____ Date: _____