DEPARTMENT OF COMPUTER SCIENCE
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

EMERGENCY MEDICAL INFORMATION

Camp/Program: CS @ ILLINOIS Sail.
Coordinator/Contact Information: Cynthia J Coleman, 217-244-4496, ccoleman@illinois.edu

STUDENT

NAME: _____ AGE: _____ BIRTH DATE: _____
MM/DD/YY

ADDRESS: _____
Street City Zip Code

YEAR IN SCHOOL: _____ NAME OF SCHOOL: _____

EMERGENCY CONTACTS

NAME: _____
Last First Relationship

ADDRESS: _____
Street City Zip Code

HOME PHONE: (___) _____ WORK PHONE: (___) _____

NAME: _____
Last First Relationship

ADDRESS: _____
Street City Zip Code

HOME PHONE: (___) _____ WORK PHONE: (___) _____

HEALTH INFORMATION STATEMENT

Check all applicable health issues. In order for the staff to maximize the safety and well-being of your daughter, we need as much accurate information as possible. To the right of the condition statement is space for you to write more about the condition checked. In case of emergency, this will be our first, and maybe only available, source of information. This information is confidential.

☐ Nervous or Mental (epilepsy, emotional stress, convulsion)

_____

_____

☐ Lung (asthma, persistent cough, tuberculosis)

_____

_____

☐

Heart or Blood vessels (increased or abnormal blood pressure, anemia)

☐ Pain in chest or Shortness of breath (heart murmur, rheumatic fever)

☐ Stomach, Diabetes, Kidney, Bladder or Intestinal (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)

☐ Any infectious diseases

☐ Skin

☐ Allergic to medicines (including penicillin, tetanus), food, Hay Fever

☐ Impaired sight or hearing, Chronic ear infections

Do you wear glasses? YES{ } NO{ } SOMETIMES{ } Do you wear contact lenses? YES{ } NO{ }

☐ Recent surgical operations, accidents or injuries

☐ Significant orthopedic and/or neuromuscular impairment (e.g.loss of limb, spinal cord injury)

☐ Current medications (list names and doses, indicate if need refrigeration)

☐ Under on-going care of a **physician** for Chronic or Recurring problem of

NAME: _____ PHONE: (____)

_____

Date of last TETANUS shot: _____

FAMILY DOCTOR

NAME: _____ CITY: _____

CLINIC/HOSPITAL: _____ PHONE: (____)_____

HEALTH INSURANCE PROVIDER

NAME: _____ POLICY NUMBER: _____

As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care will be given. I further understand that in case of serious illness/injury, I will be notified. However, if it is impossible to contact me, I give my permission for emergency treatment, x-ray or surgery, as recommended by an attending physician.

I also understand the accident insurance in effect (if provided) while at the University of Illinois campus does not cover pre-existing conditions or self-inflicted injuries.

SIGNED: _____ **DATE:**_____

(Parent/Guardian)