

**Student Travel Policy**

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***Medical Information Form***

Student's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_

Driver's License State and Number: \_\_\_\_\_ Gender: \_\_Male/\_\_\_\_Female

**Insurance Carrier Information**

Policy Holder's Name \_\_\_\_\_ Holder's Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Relation to Student \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Insurance Company Address/Phone \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Policy # \_\_\_\_\_ Plan # \_\_\_\_\_

**Emergency Contacts**

Person to Contact First (Parent):

Backup Contact (Relative or Friend):

Name \_\_\_\_\_

Name \_\_\_\_\_

Relation to Participant \_\_\_\_\_

Relation to Participant \_\_\_\_\_

Daytime Phone (\_\_\_\_) \_\_\_\_\_

Daytime Phone (\_\_\_\_) \_\_\_\_\_

Evening Phone (\_\_\_\_) \_\_\_\_\_

Evening Phone (\_\_\_\_) \_\_\_\_\_

Family Doctor: \_\_\_\_\_

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

Do you require any special accommodations due to medical limitations, disability, dietary constraints or other restrictions? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Do you have any know allergies/sensitivities to any medications? YES \_\_\_ NO \_\_\_

Please list: \_\_\_\_\_

Have you been immunized against Tetanus within the last 3 years? YES \_\_\_ NO \_\_\_

Are you on any regular medications, inhalers, antiepileptics or insulin? YES \_\_\_ NO \_\_\_

Please give details: \_\_\_\_\_

Are you allergic to any food products (nuts, etc)? YES \_\_\_ NO \_\_\_

Please list: \_\_\_\_\_

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***Medical Care Proxy Designation  
and Authorization for Urgent Care***

Should it become necessary for me to receive medical attention or treatment while participating in a College Sponsored Off-Campus Event and I am unable to provide consent, I hereby appoint the bearer of this instrument as my proxy decision maker to consent to urgent medical care on my behalf. I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that patient health information protected by HIPAA or other laws, regulations, or policies may be shared with the proxy to facilitate his/her informed decision making. I further give the selected physician permission to render whatever medical treatment he or she deems necessary and appropriate.

**AUTHORIZATION AND RELEASE**

IN WITNESS WHEREOF, the undersigned has executed this instrument as of the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Print Signature

If the above named participant is not of the age of legal majority, all legal guardian's must endorse this designation and authorization as well.

\_\_\_\_\_  
Guardian's Name (Print) Guardian's Signature

\_\_\_\_\_  
Guardian's Name (Print) Guardian's Signature

\_\_\_\_\_  
Guardian's Name (Print) Guardian's Signature

\_\_\_\_\_  
Guardian's Name (Print) Guardian's Signature