PACIFIC SUMMER HIGH SCHOOL INSTITUTE

MEDICAL INSURANCE

Student first and last name: _____ _____

Is the student covered by medical/hospital insurance? YES ☐ NO ☐

Medical insurance company: _____

Policy/group number: _____

Insured name: _____ Relationship to participant: _____

MEDICAL INFORMATION

Primary care physician: _____ Phone number: _____

Address: _____

City: _____ State: _____ ZIP code: _____ Country: _____

Does the student have any chronic or acute medical conditions that would require any accommodation to permit participation in the program/activity? YES ☐ NO ☐

If YES, please explain:

Does the student take a daily medicine? YES ☐ NO ☐ Does the medication require refrigeration? YES ☐ NO ☐

Please list any allergies to medications, food, pollen, insect bites, etc. Indicate if participant carries an EpiPen for allergic reactions:

EMERGENCY MEDICAL INFORMATION AND CONSENT

1. I understand that if my student tests positive for COVID-19 during the program, my student will need to return home. I (or a designated person) will be required to pick my student up from the University as soon as possible.

Signature of Parent/Guardian: _____ Date: _____

2. I hereby grant permission for non-prescription medication (e.g., non-aspirin pain relievers, throat lozenges, cough syrup) to be given to my student, if deemed advisable by Designated Person(s). YES ☐ NO ☐

Signature of Parent/Guardian: _____ Date: _____