Regis University Medical Information, Authorization, and Release Form

Name: _____

Program: _____

Traveling and studying out-of-state or out of the country can be mentally and physically challenging. Please provide all pertinent medical information. **This information will be used in accordance with the Family Education Rights and Privacy Act (FERPA).** By providing this information you consent to Regis University sharing this information with health care providers and those authorized individuals responsible for your care.

Do you suffer from or have you ever been treated for any of the following :	Yes	No	For everything checked yes, describe the nature of the condition, treatment, results, and dates.
Asthma/Wheezing			
Diabetes			
Heart Ailments			
Liver Problems			
Stomach/Intestinal Problems			
Cancer			
High Blood Pressure			
Joint/Back Problems			
Eating Disorders			
Kidney Problems			
Gynecological Problems			
Epilepsy/Neurological Problems			
Eye Problems			
Ear Problems			
Lung Problems			
Thyroid Problems			
Skin Diseases			
Hernia			
Drug or Alcohol Problems			
Other			

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1. How do you appraise your present health? Please describe.

2. Are you now under the care of a doctor or other practitioner for any reason? ____ Yes ____ No
   Explain:
   _____
   _____

3. Do you need any special medical or dental services? ____ Yes ____ No Explain:
   _____
   _____

4. Are you allergic to any medicines (e.g., penicillin, sulfa), insect stings, foods, or plants?
   ____ Yes ____ No Explain:
   _____
   _____

5. Please list all prescribed medications, over-the-counter medications, and/or supplements that you will take during this program. Also indicate for what condition(s) you are taking medication(s) and how often you take them:
   _____
   _____
   _____
   _____

6. What is the name and telephone number of your doctor(s)?

   Name: _____

   Specialty: _____

   Phone: _____

   Name: _____

   Specialty: _____

   Phone: _____

7. Past Health History

   Significant Childhood Illnesses/Diseases: _____

   Other Illnesses/Diseases: _____

   Significant Injuries: _____

   Operations/Hospitalizations: _____

   Blood Type: _____

8. Please include any other health related information that you think is relevant to your participation:

_____

_____

_____

_____

PROOF OF MEDICAL INSURANCE

Attach a document showing proof of current medical insurance (insurance card with effective date). I understand however, that when traveling my medical insurance may not cover my care, procedures or treatment and therefore agree to be financially responsible for all medical treatment I may receive.

I hereby certify that the information provided above is true and correct tot eh best of my knowledge.

I understand that on occasion, emergencies may arise that require medical care, hospitalization, or surgery for a participant. So that such treatment can be administered without delay, I hereby authorize the Regis University staff or faculty to secure, at my sole expense, any medical treatment deemed necessary. In the event of injury or illness where emergent medical services are required as determined in the exercise of the reasonable judgment of the Regis University staff or faculty or health care provider, and if I am unable to authorize the necessary services myself, I hereby authorize the any necessary treatment, including without limitation, the administration of anesthesia and surgical procedures, such medication as may be prescribed, and my transport to and from medical facilities, and my return to Regis University or my home of record.

Participant Signature: _____

Date _____

_____

Parent or Guardian's name and signature if participant is under age 18 Date:

PLEASE ATTACH PROOF OF CURRENT MEDICAL INSURANCE