University of Colorado Colorado Springs

PRE-COLLEGIATE DEVELOPMENT PROGRAMS

Student Emergency Information

School: **District:**

Grade Level: 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯

STUDENT INFORMATION:

Last Name : **First Name:** **MI:**

Mailing Address:

City: **State:** **Zip-Code:**

Email:

PRIMARY PHONE **PRIMARY EMAIL** **BIRTH DATE** (01/01/1901)

PARENT(S)/GUARDIAN(S) INFORMATION:

Name of Mother or Female Guardian:

Name of Father or Male Guardian:

Are the mailing address and phone number the same as your student? **Yes ☐** **No ☐**

If not, what are the Parent(s) or Guardian(s) address and phone number?

Mailing Address

City: **State:** **Zip-Code:**

Phone:

Parent or Guardian Email 1:

Parent or Guardian Email 2:

Person to contact if Parent(s) or Guardian(s) cannot be reached:

Name **Relationship:** **Phone:**

Name **Relationship:** **Phone:**

Name **Relationship:** **Phone:**

Participant's Primary Physician:

Address:

Office Phone:

Please list any Medical Insurance Coverage:

Name of Insured:

Is the student covered by this insurance? Yes ◯ No ◯ **Do you have a hospital/clinic card?** Yes ◯ No ◯

If yes, what is your card number: **If yes, where and what kind:**

Medicaid Number: **Medicare Number:**

Does your student have any of the following:

Physical or mental impairment? Yes ◯ No ◯

If yes, please describe:

Visual impairment—glasses? Yes ◯ No ◯

Extent of impairment:

Has your student had a major illness in the past five years? Yes ◯ No ◯

If yes, please explain:

Allergies: Yes ◯ No ◯ **Hay Fever:** Yes ◯ No ◯ **Sinus:** Yes ◯ No ◯ **Headaches:** Yes ◯ No ◯

Is your student presently under medical supervision or suffering from any major health problems
(i.e. asthma, sickle cell anemia, kidney, heart, blood pressure problems, etc.)? Yes ☐ No ☐

If yes, please explain:

Is your student on any special diet or does your student have any dietary restrictions? Yes ☐ No ☐

If yes, please explain:

UCCS University of Colorado Colorado Springs

Pre-Collegiate Development Programs

IN LOCO PARENTIS

Permission is hereby given for staff members of the Pre-Collegiate Development Program to act as my representative in signing for any medical services needed by my son/daughter:

Student Name: _____

I understand that every effort will be made to insure the safety and good health of the members of the Pre-Collegiate Development Program. Should an accident occur, I will in no way hold the Pre-Collegiate Development Program or its staff members responsible or legally liable.

By Signing below, I certify that the above information is true to the best of my knowledge:

Parent(s)/Guardian(s) Signature **Date**

Student Signature **Date**