



EMBRY-RIDDLE
AERONAUTICAL UNIVERSITY

**Upward Bound Programs
Participation and Medical Release Form**

Participation in an activity of any type is at your own risk. You are advised that participation may expose you (or your child) to potential risks of physical harm or damage to personal property. You will be held personally responsible for any expenses you may incur as a result of any injuries sustained or damage to personal property sustained while participating in activities.

It is therefore agreed and understood that the undersigned freely and voluntarily chooses to assume personal liability for any injury that may occur as a result of participation by you or your child in activities and for any damage sustained to personal property. The undersigned further agree to save and keep harmless and indemnify Embry-Riddle Aeronautical University against any and all liability, claims, and costs of whatsoever kind and nature of injury, death and for loss or damage to any property occurring in connection with or in any way incident to or arising from participation in any activity, resulting in whole or in part from the negligent acts, fault or omissions of the University, any member, employee, agent, or representative of the University.

Student Name (Print): _____

Signed: _____ Date: _____

(Parent or Guardian)

I hereby grant permission to the Upward Bound Programs, Embry-Riddle Aeronautical University or the University physician to render any health care or emergency treatment to myself/son/daughter/ward. I also grant permission for the Health Services, the University Physician, and the director of Upward Bound Math\Science (or his/her designee) to arrange for healthcare, emergency treatment or hospitalization at an accredited hospital or other medical, psychological, or dental care facility when considered necessary by Health Services, the University Physician, and the Upward Bound Programs director or designee.

Student Name (Print): _____

Signed: _____ Date: _____

(Parent or Guardian)

Day Phone:(____)_____ Evening Phone:(____)_____

Alternate Emergency Contact: _____

Relationship to Student: _____ (Phone): (____)_____

Does your son/daughter have medical insurance? ____ Yes ____ No

(Parents/guardians are responsible for all medical expenses incurred by the student.)

PLEASE PROVIDE A COPY OF YOUR CURRENT MEDICAL INSURANCE CARD

Health Insurance Company: _____

Policy Number: _____

Company Phone Number: _____

Group Number/Code: _____

You MUST INCLUDE A CURRENT COPY OF YOUR MEDICAL INSURANCE CARD FOR OUR RECORDS!

EMBRY RIDDLE AERONAUTICAL UNIVERSITY

Prescott Campus
(928) 777-6653
(928) 777-3850 FAX

Dear Embry Riddle students and parents,

Welcome to the university! The staff of Health Services is committed to providing you with the health care and preventive education that will support your academic and co-curricular goals. Please read the following important information prior to completing the STUDENT MEDICAL REPORT and returning it to Health Services in the envelope provided. Please make sure that the authorization for treatment, below, has been signed. The information you include in this record is confidential and is not released for students 18 years of age and older without your written consent except in cases of extreme medical emergency or by court order. Parents or legal guardians of students under age 18 have legal access to medical records except for those regarding issues of contraception and sexually transmitted infection. Health Services staff members will use your personal medical information for purposes of diagnosis, care and consultation. Please feel welcome to contact us should you have any questions regarding the completion of this form, immunization requirements or your health care while enrolled at the university.

Sincerely,
Maureen Bridger, M.Ed., RN, BC
Director, Health Services
Daytona Beach Campus

Sincerely,
Sandra F. Palmer, RN, ADN
Director, Health Services
Prescott Campus

IMPORTANT INFORMATION-----PLEASE READ CAREFULLY

HEALTH INSURANCE AND HEALTH CARE EXPENSES: While the Health Services fee covers a range of campus-specific clinical services, fees for specialty care, hospitalization, laboratory tests, radiology studies and pharmacy charges are the responsibility of the individual student. Therefore, we strongly urge students to carry health insurance. **PLEASE ATTACH A COPY, FRONT & BACK, OF YOUR INSURANCE ID CARD, IF ANY.**

NOTE: International students are required to carry health insurance. For specific information, please contact the campus director of International Student Services at assadj@erau.edu (Daytona Beach) or frahera@erau.edu (Prescott).

Please be aware that if you are insured by an HMO (Health Maintenance Organization), you might not be covered for non-emergency services while on campus and outside the plan's network. We urge you to contact your plan administrator for details on your coverage. Also, some health insurance plans are PPOs (Preferred Provider Organization) and require that you use "preferred" clinicians for off campus care that you might require. Your plan administrator can provide you with a list of approved providers for the community in which the campus is located.

A group policy is available for purchase with premiums paid directly to the broker each semester or annually. For additional information on this policy, contact the broker, Student Resources, at 800-237-0903, ext. 6239/6240, or visit www.studentresources.com.

IMPORTANT INFORMATION

Please read the detailed information included with this MEDICAL REPORT form regarding meningococcal meningitis and Hepatitis B disease. Although neither campus has ever experienced an outbreak of bacterial meningitis, a number of college and university campuses across the nation have, sometimes with dire consequences to the life and health of the students, faculty and staff involved. Hepatitis B is a more insidious disease; students can become infected and pass the virus to others before they realize they are ill.

The risk for infection is slightly increased for students, due to the communal nature of the higher education experience. Health Services believes it is important for all students and their parents to be informed and consider the benefits vs. the risks of vaccination. Prior to leaving home, please discuss these concerns with your personal physician.

In an effort to afford students an opportunity to protect themselves, Health Services will sponsor campus clinics to be administered by a national health care firm that specializes in preventive immunization. Clinic schedules and locations will be announced at each campus. Fees associated with these clinics are the responsibility of the individual student.

EMBRY RIDDLE AERONAUTICAL UNIVERSITY

For Office Use Only:
OK to FILE: _____

Social Security # ___/___/___ Expected Date of Entry ___/___/___ Degree Program _____

Name _____

Date of Birth ___/___/___ Sex ___ Height _____ Weight _____ Marital Status _____

Permanent Address _____

No. & street City State/Zip Code Country Phone

Emergency Contact _____ Phone (1) _____ (2) _____

PERSONAL MEDICAL HISTORY

Do you have any **allergies**? If so, please indicate (include medications, insect stings, environmental factors, food):

Do you : Smoke? ___ NO ___ YES Use other Tobacco Products? ___ NO ___ YES Consume Alcohol? ___ NO ___ YES

Please check if you are being treated or have been treated in the past for any of the following and **indicate the year**. **Attach a physician statement/summary for any items checked, except chicken pox.**

	Year		Year
Alcohol/Drug Dependency		Heart Murmur/Disease	
Anemia, Blood Disease		Hepatitis	
Arthritis, Joint Disease, Bone Disease		High Blood Pressure	
Asthma		Hypoglycemia	
Blood Clot/Phlebitis		Lyme Disease	
Cancer		Malaria	
Chicken Pox		Migraines	
Diabetes (indicate type)		Psychological Problems	
Digestive Disorders		Rheumatic Fever	
Epilepsy, Seizures		Thyroid Disease	
Head Injury		Tuberculosis	
		Other	

Personal physician _____

Name Address Phone

Are you currently under the care of any clinical practitioner for any other condition(s)? **Please list and attach summary.**

List medications taken recently or currently (include birth control, vitamins and herbal preparations):

List operations and/or hospitalizations (include reason and year):

EMBRY RIDDLE AERONAUTICAL UNIVERSITY HEALTH SERVICES

NAME _____

DATE OF BIRTH ____/____/____

➔ Please include a copy of student's immunization records.

REQUIRED IMMUNIZATION DATA

The immunization policy is designed to protect the health of all students. Students who fail to comply will have a HOLD placed on class registration and/or will be denied class attendance pending satisfactory completion of required data.

A licensed health care provider must certify immunization data; home records or self-reports are unacceptable. Copies of school or military immunization records will be accepted with appropriate dates and signatures indicated.

A. MMR (MEASLES/MUMPS/RUBELLA): All students born after Dec. 31, 1956 must provide proof of two doses administered on or after Jan 1, 1968 and on or after the first birthday. The second dose of MMR must be administered 30 days or more after the first dose. Alternately, students may provide copies of laboratory reports indicating positive antibody titers for these diseases. Students born prior to Dec. 31, 1956 are considered to have natural immunity.

1st MMR ____/____/____

2nd MMR ____/____/____

HEPATITIS B AND MENINGOCOCCAL MENINGITIS: We request that you read the accompanying information regarding these diseases and their prevention through vaccination. All students who reside in University Housing must either document the immunizations for Hepatitis B and meningococcal meningitis OR complete the waiver in section B below. We urge you to discuss these concerns with your personal physician and consider vaccination. There will be opportunities for vaccination at campus-sponsored clinics during Orientation and campus-specific dates to be announced.

Hepatitis B dose 1: ____/____/____
dose 2: ____/____/____
dose 3: ____/____/____

Meningococcal Meningitis ____/____/____

➔ [Redacted Signature] ____/____/____
Physician or authorized signature (Parent signature) date License # & Office Stamp with Address

B. I have received and read the detailed information provided regarding the risks of contracting meningococcal meningitis and Hepatitis B disease and the potential benefits of being vaccinated to reduce those risks.

___ I decline to receive Hepatitis B vaccines.
___ I decline to be vaccinated for meningococcal meningitis.

[Redacted Signature] Date ____/____/____
Student Signature [Redacted Signature] Date ____/____/____

AND by parent or legal guardian if under 18 and single

C. RECOMMENDED IMMUNIZATION DATA

Polio (most recent dose IPV) ____/____/____ Hepatitis A dose 1 ____/____/____
Td/Tdap(most recent dose) ____/____/____ dose 2 ____/____/____
Varicella (Chicken Pox) ____/____/____ TB skin test (Mantoux) ____/____/____
____mm ____Pos ____Neg

Physician or Authorized Signature (Parent) Date License # and office stamp with Address
➔ [Redacted Signature] ____/____/____

AUTHORIZATION FOR TREATMENT

I hereby grant permission to the Health Services or Counseling Center staff of Embry Riddle Aeronautical University or the University Physician(s) to render any health care or emergency treatment to myself/son/daughter/ward. I also grant permission for the above referenced ERAU staff to arrange for health care, emergency treatment or hospitalization at an accredited hospital or other medical, psychological or dental care facility when considered necessary by the Health Services or Counseling Center staff or University Physician(s).

➔ Student signature [Redacted Signature] AND by parent or legal guardian if under 18
➔ Signed [Redacted Signature] Date ____/____/____