MEDICAL RELEASE

TRIO UPWARD BOUND

MONTANA STATE UNIVERSITY BILLINGS

Parent Information

The law requires that before medical services can be performed, permission of the parent(s)/guardian(s) must be obtained. In the event of serious illness or accident, every effort will be made to contact you. However, in the event that a delay in medical or surgical treatment might be detrimental to the health of the student, authorization for consultation and treatment by physicians is requested. This form will authorize staff of the UpwardBound program to carry out the following actions regarding the medical care of your student. This authorization will be in effect any time your student is participating in an UpwardBound sponsored activity.

Student Information

Student's Name _____

Address _____ City _____ State ____ Zip _____

Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Contact No: _____ Contact No: _____

Medical History

Do you have any conditions that would interfere with your schoolwork, sports, or physical education? Explain

_____

_____

Are you under a doctor's care or taking any prescription medication? Explain:

_____

_____

Do you have any allergies, especially to food or medication? Please list:

_____

_____

Health Insurance Information

Health Insurance Company: _____ Policy Number _____ Group Number _____

Doctor/Clinic Preferred: _____ Phone _____

*This Upward Bound Project is 100% federally funded aannually.

Continued on Reverse

Authorization

I, the parent or guardian of the above named student, certify that I am this students parent and that this release will be in effect for the duration of my students participation in the Upward Bound Program.

I authorize Upward Bound staff to obtain the services of a qualified physician and/or to use local hospitals and clinics for the treatment of emergency illness or accident and to sign, as a competent adult, forms permitting examination and possible treatment. I understand that the physicians and hospitals are reluctant and sometimes unwilling to examine and treat patients without such authorized signatures. I understand that in the event of accident or illness all actions of the Upward Bound staff will be guided in the best interest of my student and that Upward Bound will seek only emergency procedures. Any major or prolonged treatment will be undertaken only with my specific permission. I hereby release whatever medical and dental information is deemed necessary and appropriate in providing the proper health care for my student. Such information will be regarded as confidential and shared with medical practitioners for emergency care only. I further understand that I am responsible for all medical and hospital expenses incurred by my student and have adequate insurance or a means to cover such expenses.

Parent or Guardian's Printed Name _____ Date _____

Parent or Guardian's Signature _____

Return this application to:
Office of Educational Access
1500 University Dr | Billings, MT, 59101 | phone: 406.657.2116 | email:TalentSearch@msubillings.edu