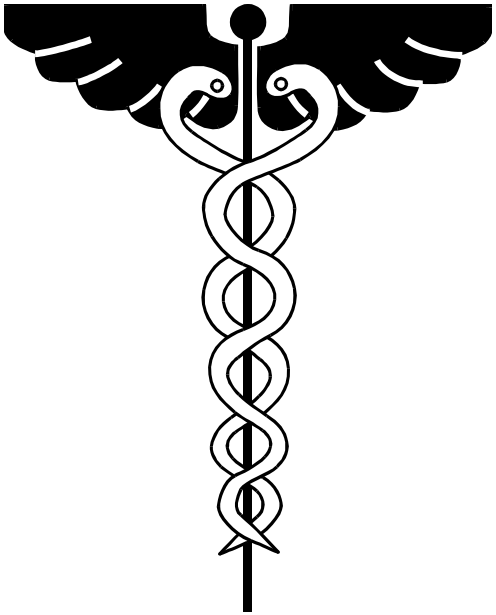
Baldwin-Wallace College Upward Bound **275 Eastland Road Berea, Ohio 44017** **Phone: (440) 826-2208**

Date:
Last Name:_____ First Name:_____
Date of Birth:_____/____/_____ Age:_____ Social Security Number: _____-____-_____
Date of last Tetanus Booster: _____
Are you allergic to any medicine?_____ If yes, list:_____
Is there any medicine you cannot take?_____
Is there any medication you take regularly?_____
List any major medical problems or surgeries that you have had:_____
_____



Please place an X next to the disease that you currently have or have had:

	Asthma		Stomach or Intestinal Problems
	Skin Problems		Kidney or Bladder Infection
	Ear Problems		Diabetes
	Frequent Ear Infections		Thyroid Disease
	Deafness		Sinusitis
	Eye Problems		Arthritis
	Wear glasses or contacts		Bone and Joint Problems
	Heart Disease		Significant Injuries
	Heart Murmur		Cancer
	High Blood Pressure		Epilepsy
	Rheumatic Fever		Tuberculosis
	Yellow Jaundice, Hepatitis		Other:
	Liver Disease		Other:

Authorization For Medical Procedures

Permission is hereby granted to the Baldwin-Wallace College Upward Bound Program to allow the College Health Center or any licensed physician, hospital or dentist to perform medical services on_____(Student's Name).

No operations will be performed without the parent(s)/guardian(s) being contacted and fully informed. Any cost incurred for medical treatment that are not covered by Upward Bound insurance must be assumed by the parent(s)/guardian(s). The Upward Bound Insurance only covers accidental injury.

_____ _____
Date Parent /Guardian Signature

_____
Notary Signature

Witness My hand and official seal on this _____ Day of _____, 20_____