





Hampton University's 40th Annual High School Day 2018

STUDENT HEALTH FORM

THIS FORM MUST BE COMPLETED BY THE PARENT/GUARDIAN

Type or Use Black Ink ONLY. Do Not Leave Any Blanks. Use N/A Where It Applies.
NOTE: This CONFIDENTIAL Information Will Be Used By the Health Care Chaperones.

STUDENT'S FULL LEGAL NAME

Male Female

DATE OF BIRTH AGE

STREET ADDRESS

CITY STATE ZIP CODE

PHONE AREA CODE/NUMBER

IN CASE OF EMERGENCY NOTIFY

WORK/HOME PHONE# AREA CODE/NUMBER

CELL/MOBILE PHONE# AREA CODE/NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

HEALTH INSURANCE CARRIER

Primary/Policy Holder's Name/Policy #

Describe in FULL Detail ALL MEDICAL CONDITIONS to include all restricting physical and/or emotional disabilities. (Identify all special needs, i.e., seizure precautions, asthma, use of crutches or need for special emotional support. etc.)

List all allergies

List all medications

Name of Physician Phone AREA CODE/NUMBER

I hereby certify that all statements made herein are correct and true. I will hold harmless the WASHINGTON, DC CHAPTER OF THE NATIONAL HAMPTON ALUMNI ASSOCIATION, INC., of any injuries or harm my student may incur due to omissions or false statements given about his/her health. IN CASE OF EMERGENCY, I HEREBY GIVE MY PERMISSION FOR MEDICAL TREATMENT TO BE GIVEN TO THE ABOVE NAMED STUDENT AS INDICATED BY MY SIGNATURE BELOW:

Parent/Guardian's Signature

Date

Provide a photocopy of a valid Health Insurance Card with this application and BRING the actual Health Insurance Card for verification purposes with a current photo ID to be carried during this trip.