

UMBC Classic Upward Bound Health Update, Allergy and Medication Form

Name of Student _____

Student Social Security Number (For Internal Use Only): _____

We follow a policy of allowing students to administer their own medications unless the parent is not comfortable with this arrangement or unless CUB staff has any concerns about the possibility of problems with a particular medication. If a parent has concerns, he or she can turn the medications over to our Residential Director (RD) and the RD will administer the medication. It must come in the original container with clear instructions and we must have a signed permission form from the parent. **For prescription medication, please fill one form out for each medication.**

Prescription Medication:

_____ My child will not be taking any prescription medication during his/her stay at Upward Bound.

_____ My child will self administer his/her prescription medication Fill out information below so we know what the child will bring. UB does not take responsibility for this.

_____ My child will take prescription medication during his/her stay at Upward Bound. I authorize the Upward Bound staff to store and administer the following medications to my child:

Name of Licensed Prescriber _____

Name of Medication _____

Medical condition related to prescription _____

Dose given at UB _____

How should it be given _____

How often, what time of day _____

What day should the medications be stopped _____

How should it be stored _____

Specific directions (ex: on empty stomach with water) _____

Specific precautions _____

Possible side effects _____

Over-the-counter (non-prescription) Medication:

_____ My child should not take any over-the-counter (non-prescription) medication during his/her stay at Upward Bound.

_____ My child may self administer over-the-counter (non-prescription) medication during his/her stay at Upward Bound including: (PLEASE CIRLE) UB does not take responsibility.

Tylenol (Acetaminophen) Advil (Ibuprofen) Cough syrup Stomach relief medication

Naproxen Sodium Antihistamine Antibacterial cream Aspirin

Other: (please explain) _____

Allergies:

Does your child have any allergies? Please list _____

How severe are the reactions?

Answer for each allergy: ___Mild ___Moderate ___Fairly Severe ___Could be life threatening

What is your doctor's guidance for when there is a reaction? _____

Does your child have any serious medical conditions or health issues we should know about? If yes, please explain _____

Is there anything else we should know about your child's medical history or situation that may come up at Upward Bound? _____

Parent/Guardian Signature _____ Date _____

IN CASE OF EMERGENCY, CALL:

(Name) (Relationship) (Home Phone) (Work Phone)

(Name) (Relationship) (Home Phone) (Work Phone)

HEALTH INSURANCE/RELATED INFORMATION

Name (Insured/Company): _____ / _____

Number (Co./Med. Asst): _____ / _____

Physician/Telephone #: _____ / _____

Medication Allergies: _____ / _____