HARRIS-STOWE STATE UNIVERSITY

Academy for Science & Mathematics

Summer Activities for Youth Health Information and Consent Form

To be completed by the participant's **PARENTS**. Please return with the Academy for Science & Mathematics application.

Date_____

PERSONAL INFORMATION

PROGRAM NAME			PROGRAM DATES
PARTICIPANT'S LAST NAME	PARTICIPANT'S FIRST NAME		M.I.
GENDER ❑ FEMALE ❑ MALE	ETHNICITY ❑ AFRICAN-AMERICAN ❑ AMERICAN INDIAN ❑ ASIAN ❑ LATINO(A) ❑ MIDDLE EASTERN ❑ PACIFIC ISLANDER ❑ WHITE ❑ OTHER_____		
DATE OF BIRTH _____/_____/_____	TELEPHONE ( )	ALTERNATE TELEPHONE ( )	
ADDRESS	CITY	STATE	ZIP CODE
MOTHER (OR GUARDIAN) LAST NAME	MOTHER (OR GUARDIAN) FIRST NAME		M.I.
FATHER (OR GUARDIAN) LAST NAME	FATHER (OR GUARDIAN) FIRST NAME		M.I.
MOTHER (OR GUARDIAN) WORK ADDRESS	CITY	STATE	ZIP CODE
MOTHER (OR GUARDIAN) WORK TELEPHONE ( )	MOTHER (OR GUARDIAN) CELL PHONE ( )		
FATHER (OR GUARDIAN) WORK ADDRESS	CITY	STATE	ZIP CODE
FATHER (OR GUARDIAN) WORK TELEPHONE ( )	FATHER (OR GUARDIAN) CELL PHONE ( )		
EMERGENCY CONTACT FIRST NAME	EMERGENCY CONTACT LAST NAME		
EMERGENCY CONTACT RELATIONSHIP TO PARTICIPANT	EMERGENCY CONTACT TELEPHONE ( )		

HEALTH INFORMATION

Is there any health information regarding your child that the program staff and faculty should be aware? Please check the appropriate boxes below and provide an explanation.

❑ Handicap Conditions_____

❑ Diseases_____

❑ Allergies_____

❑ Activity Restrictions_____

❑ Regular Medications_____

❑ Other_____

_____

PHYSICIAN INFORMATION

In case of emergency, please contact the following physician.

PHYSICIAN LAST NAME	PHYSICIAN FIRST NAME		
PHYSICIAN ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER ( )			

CONSENT OF TREATMENT

I approve my child's attendance and participation in all program activities as long as they are in accordance with the health information provided on the previous page.

I hereby authorize Harris-Stowe State University Health Services to provide or obtain medical care for _____

_____, a minor. I understand that I will be responsible for any charges incurred for such care.

SIGNATURE OF PARENT OR GUARDIAN, IF CHILD IS UNDER 18 YEARS OF AGE	DATE _____/ _____/ _____
RELATIONSHIP TO MINOR	

SIGNATURE OF PARTICIPANT, IF OLDER THAN 18	DATE _____/ _____/ _____

Submit completed health information and consent form and liability release form to:

Dr. Lateef Adelani
Dean, College of Arts & Sciences
Harris-Stowe State University
3026 Laclede Avenue, Room 317
St. Louis, MO 63103
Phone: (314) 340-5349
Fax: (314) 340-3699
E-mail: AdelaniL@hssu.edu
University Website: www.hssu.edu/rms