Calvin COLLEGE ACCESS PROGRAMS

Calvin University Summer Programs Medical Release Form

Private information will remain confidential and will not be released except as allowed by law.

Participant's Name: _____ Age: ____ ___ Male ___ Female

Address: _____ Birth Date: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian's Name (1): _____ Daytime Phone: _____

Parent/Guardian's Name (2): _____ Daytime Phone: _____

Family physician: _____ Phone: _____

Insurance Company: _____

Policy Number: _____

Policy Holder: _____

Name of carrier as on card: _____ Carrier's Birthdate ___/___/____

Relationship to student: _____

Address of carrier: _____ City: _____

State: _____ Zip code: _____

Important: Please send a picture of both the front and back of the insurance card

Designated alternate if parent is unavailable:

Name: _____ Phone: _____

Please identify any significant medical conditions or psychological conditions (i.e., asthma, diabetes, allergies/reactions to medications, foods, bee stings, depression, etc.), major illnesses, or injuries that may affect your child's participation in Calvin University activities.

_____

_____

_____

Does your child take any medications at home? If so, please list them below.

_____

_____

_____

Do you authorize Calvin University and the College Access Programs staff to give your child basic care medication (e.g., Ibuprofen, Tylenol, etc.)? ____YES ____NO

I understand that Calvin University does not provide medical insurance for program participants. I hereby confirm that my child is covered by the health insurance policy listed above. I authorize Calvin University and its designated personnel to secure medical attention or counseling services for my student if any such care is necessary. I hereby authorize medical or mental health counseling services when deemed appropriate by Calvin University personnel.

Specifically, if my student is presented to Calvin Health Services for diagnosis and treatment, I consent to the rendering of such care, including diagnostic assessments and medical treatment (including lab testing sent to local hospital lab if needed) by authorized health care providers, as their professional judgment deems necessary. Insurance will be billed when applicable and I will be responsible for the balance of the cost of care provided.

I understand that I may be asked to pick up my child within 24 hours if further treatment is needed that cannot be provided during this program and may represent a risk for my child and/or its participants.

Parent/Guardian signature: _____ Date: _____

Program: _____

This form must be completed and returned with all enrollment documents to College Access Programs: 3201 Burton SE, Grand Rapids, MI 49546 or collegeaccess@calvin.edu.