



**UPWARD BOUND  
Medical Needs and Contact Information**

Student Name: \_\_\_\_\_

High School:    Central                      Hillcrest                      Parkview

**In the event of a non-medical emergency, a UB staff member may administer each of the following medications:**

Acetaminophen (Tylenol)	YES	NO
Ibuprofen (Motrin or Advil)	YES	NO
Naproxen (Aleve)	YES	NO
Motion Sickness Medication (Dramamine)	YES	NO
Upset Stomach Reliever (Pepto Bismol or Tums)	YES	NO

**I understand that my child will be administered medication at the prescribed dosages as requested by my student and written recorded will be kept of medication distribution.**

\_\_\_\_\_  
**Parent or Guardian Signature**

\_\_\_\_\_  
**Date**

**List any allergies or substances to which your child has reacted unfavorably (Drug, medicine, food, bee stings, etc):**

\_\_\_\_\_  
\_\_\_\_\_

**List any surgeries your child has had since birth:**

\_\_\_\_\_  
\_\_\_\_\_

**In case of emergency, please contact the following:**

Primary Care Provider \_\_\_\_\_ Phone #: \_\_\_\_\_

Hospital Preference \_\_\_\_\_ Phone #: \_\_\_\_\_

Dentist \_\_\_\_\_ Phone #: \_\_\_\_\_

**Emergency Contact Information (Please Provide 3 including yourself):**

**Parent/Guardian** \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

**Contact 2** \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

**Contact 3** \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Do you carry insurance on your child:    YES    NO    Insurance Company \_\_\_\_\_  
Policy Number and Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
**Parent or Guardian Signature**

\_\_\_\_\_  
**Date**

