BMLA Emergency Contact, Medical Background and Emergency Treatment Release

The following information is being gathered as part of an effort to keep all of our Academy members safe and secure during their time with the Black Male Leadership Academy. Please complete all sections of this document. If the question does not apply to the BMLA participant, please print N/A in that question. Please print clearly and legibly. BMLA staff may follow-up with you regarding incomplete or illegible responses to questions. On page 7 of this form you will have the opportunity to address any issues we feel you missed.

BMLA Participant Physical Identifying Information

Eye Color: _____ Hair Color: _____ Height:_____

Any Identifying Marks (for example: birth marks)

_____

_____

Emergency Contact and Authorization for Pick up Information:

Parent/Guardian Name: _____

Home Address: _____

City: _____ State: ____Zip: _____

Home Phone: _____

Cell Phone: _____Work Phone: _____

Parent/Guardian Name: _____

Home Address: _____

City: _____ State: ____Zip: _____

Home Phone: _____

Cell Phone: _____Work Phone: _____

Participant Name: _____Date of birth: ___/___/_____
(Last, First)

If parent(s)/guardian(s) cannot be notified, please contact the following individual(s) who have my permission to pick-up my child and to act on my behalf:

Name: _____

Relationship to child: _____

Home Phone: _____

Work Phone: _____ Cell Phone: _____

Name: _____

Relationship to child: _____

Home Phone: _____

Work Phone: _____ Cell Phone: _____

Medical information

In the following grid please list all of the following that apply:

1. Known Allergies and Chronic Conditions (for example: Type-1 Diabetes or Asthma)
2. The reaction caused by the allergy or chronic condition
3. The methods used to control the reaction (for example an Epipen, asthma inhaler,)

Type of Allergy or Chronic Condition	Please Check Box if Known	Reaction caused by Allergy or Chronic condition	Management of Reaction or Chronic Condition
Asthma	☐		
Medicines	☐		
Foods	☐		

Participant Name: _____Date of birth: ___/___/_____
(Last, First)

Insect Stings	☐		
Animals	☐		
Diabetes	☐		
Other	☐		

Do any of the listed allergies require an Epipen, inhaler, or other prescribed medications? ☐Yes ☐No

Will your child take medicine while attending the BMLA Summer Institute? ☐Yes ☐No

Does your child take medicine on a regular basis? ☐Yes ☐No **(if no please skip to the next page)**

If yes, please list the medicine, dosage and frequency: _____

_____

_____

Does your Child require assistance with their medication? ☐Yes ☐No

If yes, please explain the type of assistance required: _____

_____

_____

Are there any physical limitations on your child's participation in the BMLA Summer Institute?

Participant Name: _____Date of birth: ___/___/_____
(Last, First)

☐Yes ☐No

If yes, please provide specific details: _____

_____

_____

Are there any behavioral or mental health issues we should be aware of? □Yes □No

If yes, please provide specific details: _____

_____

_____

Physicians Information (Optional and if known)

Name of Physician:

_____

_____

Address: _____

Telephone: _____

Name of Dentist:

_____

Telephone: _____

Other Doctor

Type:

_____

Name of Physician:_____

Address: _____

Telephone: _____

Participant Name: _____Date of birth: ___/___/_____
(Last, First)

This health history is correct to the best of my knowledge, and the participant described has permission to engage in all academy activities except as noted.

Authorization for Emergency Treatment:

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child.

I hereby give permission and authorize Black Male Leadership Academy staff, Roosevelt University faculty or staff or their designee to monitor prescribed and over the counter medicines and provide basic First Aid in the event of an emergency, and where necessary, to seek emergency medical treatment for my child, including ordering of x-rays or routine tests as prescribed by medical professionals. I agree to the release of any records necessary to appropriate medical personnel and for health insurance purposes. I give permission for BMLA director, his/her designee, or Roosevelt faculty or staff member staff to arrange necessary transportation for my child to a hospital or treatment center. In addition, I hereby give permission to the physician selected by the BMLA director, his/her designee, or Roosevelt staff or faculty member to secure and administer treatment, including hospitalization, for the above named BMLA participant. I understand that if I do not have medical insurance, I, as the parent or guardian, will be responsible for any and all medical expenses in the event of a sickness and/or injury.

This form may be copied.

_____
Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

If applicable, please provide the following Medical Insurance Information for the participant:

Medical Insurance Provider: _____

Policy or Group #: _____

Name of Subscriber: _____

Insurance Phone Number: _____

Dental Insurance Provider: _____

Policy or Group #: _____

Name of Subscriber: _____

Insurance Phone Number: _____

Extended / Additional Information

Participant Name: _____Date of birth: ___/___/_____
(Last, First)

Please list any information that continues from the form above (such as medication list, restrictions, etc.) here and sign on the next page:

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Printed Name of Parent or Guardian

_____ _____

Signature of Parent or Guardian Date