



# iSTEM Summer Program

## Medical Form

Program Name: \_\_\_\_\_

All parents/guardians of students attending the UCF iSTEM Summer Program must fill out this form and send it in PRIOR to the start of the program, **along with a copy of their insurance card**. Participation in the UCF iSTEM Summer Program is NOT allowed without this form.

### **Basic Personal Information:**

STUDENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

STUDENT CELL PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Sex: \_\_\_\_ Female \_\_\_\_ Male RACE/ETHNICITY: \_\_\_\_\_

### **Emergency Contact Information:**

**REQUIRED:** PARENT/GUARDIAN #1: NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN #2: NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

**REQUIRED:** PERSON TO CONTACT IN CASE OF EMERGENCY IF PARENTS/GUARDIANS LISTED ABOVE CANNOT BE REACHED:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

### **Medical Information:**

PHYSICIAN'S NAME: \_\_\_\_\_ PHYSICIAN'S PHONE: \_\_\_\_\_

INSURANCE'S NAME: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_



Medical Information:

Please list any current medical concerns or medical history we need to know about your child: (Ex. past injuries, current conditions, physical limitations, etc.)

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List any allergies your child has: (Ex. medications, stings, food, iodine, latex, etc.)

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List any medications your child is currently taking, the purpose, dosage, and times taken:

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I hereby authorize my son/daughter, \_\_\_\_\_, to take full responsibility of his/her medication, and to administer it to himself/herself. I have discussed with my child what the medication treats, how to take the medication, when to take the medication, and other vital information about the medication. I realize that the iSTEM Summer Program is not responsible for checking up on whether or not he/she has taken his/her dosage. I also understand that my child may be dismissed, at UCF's sole discretion, without warning if he/she is caught sharing prescription medication with others.

I understand that UCF does not supply health insurance for students participating in the iSTEM Summer Program and it is my responsibility as parent/guardian to provide appropriate health insurance authorized for use in the State of Florida or incur any expenses resulting from illness or injury.

Parent/Guardian Initial \_\_\_\_\_

I hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND HOLD HARMLESS for any and all purposes the University of Central Florida (including but not limited to its College of Engineering and Computer Science), the Board of Trustees of the University of Central Florida, the State of Florida, the Florida Board of Education, the Florida Board of Governors, and their employees, officers, agents, servants, volunteers and students and all organizations involved in the coordination, hosting, and staffing of and contribution of equipment and supplies to the conference/workshop, and also their agents, servants, and employees (with all of the above collectively referred to as RELEASEES), FROM ANY AND ALL LIABILITIES, RESPONSIBILITIES, CLAIMS, DEMANDS, DAMAGES, ACTIONS, JUDGMENTS, EXPENSES (INCLUDING FEES AND COSTS), CAUSES OF ACTION OR INJURY, INCLUDING DEATH that may be sustained by my child due to my child administering his/her own medication or my child's failure to do so, while at the UCF iSTEM Summer Program or otherwise and/or whether caused by RELEASEES' negligence or otherwise.

**By signing or typing your name and initials on this form, you confirm that you have reviewed the above information and agree to follow the rules of the program.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Cell Phone: \_\_\_\_\_

Student Cell Phone (if applicable): \_\_\_\_\_