DLA STUDENT NAME ________________________________ SOCIAL SECURITY NUMBER ______________

STUDENT HEALTH INVENTORY

Must be completely filled out and returned. We use this information to: (a) Brief kitchen staff about diet needs; (b) Educate counseling staff about camper needs; and (c) Provide healthcare staff with background about your child. *Receiving adequate information prior to your child's arrival is crucial to our ability to provide a supportive environment.*

Gender____________ Age___________ Birthdate__________/__________/_____________
Parent or Guardian____
Day Phone ____________________________ Evening Phone_______________________
Cell Phone____________________________ City ______________________________
Address____
State ___________________________ Zip ___________________________________
Doctor's Name___________________________________ Phone ____________________
Dentist's Name__________________________________ Phone ____________________

HISTORY: Please attach a list of any conditions, problems, dietary needs or allergies (including insect bites) your child has.

MEDICATION: Provide complete information. Bring enough medication to last the entire session. ALL medications, including vitamins and herbal supplements, MUST be in pharmacy/original containers and be appropriately labeled. For safety all medication will be stored in the locked RA office. Attach more information if needed.

#1 Name of medication: ________________________________ Dosage: _______
How often each day? ________ Reason for taking: __________________________

#2 Name of medication: ________________________________ Dosage: _______
How often each day? ________ Reason for taking: __________________________

#3 Name of medication: ________________________________ Dosage: _______
How often each day? ________ Reason for taking: __________________________

My child has permission to take: _____Tylenol ____ Pepto-Bismol
Ibuprofen
_____ Benadryl _____ Calamine Lotion

EMERGENCY: List names and phone numbers of persons we should call in an emergency and we couldn't reach a parent.

____
(name) (tel. no.)

____
(name) (tel. no.)

LOCAL HOSPITAL PREFERENCE: ST JOHNS COX

WHAT HAVE WE FORGOTTEN TO ASK? Please attach any additional information we should know.

INSURANCE VERIFICATION: **Each student must be covered by medical insurance provided by parents or guardians. (Application is not complete without this information.)** It is understood that DLA staff use insurance information in the event of medical emergency to preserve the immediate well-being of the named student. Any expenses incurred as a result of use of these provisions will be the responsibility of the undersigned individuals. The undersigned individuals grant permission for treatment.

____ is covered by health and accident
Policy (medical) ____
Policy Number ____
Insurance Co. ____
Name of Policy Holder: ____
Social Security # __________________________________
Address of policy holder (if different from student)

____

AUTHORIZATION: My child has my permission to participate in classes, activities and field trips with DLA. I accept full responsibility for my child. If an accident should occur injuring my child, including loss of life or limb, I authorize treatment and I hereby release the teacher, driver, sponsors, administrators, or other associated persons, together with DLA (and its officers and agents) and Drury University (plus its agents, employees and Board), from any liability thereon. Drury's representatives have my authorization to transport my child for medical care. I give permission to the physician selected to order X-rays, routine tests, and treatment for the health of my child. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the child. This form may be photocopied. I understand that information about my child's health will be shared on a "need to know" basis.

I further agree that I will indemnify and hold harmless all such persons and organizations from any loss, cost, judgment or other harm, including attorneys' fees, which might come to them if my child or anyone claiming by or through my child should ever institute litigation against any such person or organization for any reason touching upon or arising from my child's DLA experience. This agreement binds my heirs and successors.

I grant permission for DLA or its designate to photograph, record or videotape my child during DLA activities and to use those materials for promotional or other purposes chosen by the Administrative Board for Pre-College Programs. I agree that my child must abide by the rules of the DLA program, including dormitory general rules and any specific additional instructions by DLA staff.

____
Parent/Guardian Signature & Printed Name

____
Emergency Number for Parent or Guardian