University Honors Program
PO Box 210007
Cincinnati, OH 45221-0007

700 Swift Hall
Phone (513) 556-6254
Fax (513) 556-2890

STUDENT HEALTH/EMERGENCY TREATMENT AUTHORIZATION

The medical review of this form and admission into a program are independent of each other. The purpose of this form is to help the University Honors Program provide appropriate assistance to you should the need arise during your participation in this program. It is important that we be aware of any medical or emotional needs, past or current, which might affect your ability to participate in this program. This information will be kept confidential in accordance with the law. Any disclosure of such information will be made only to the most appropriate individuals and with the highest level of discretion in order to protect student privacy. Relevant information will be shared with program staff, faculty, or appropriate professionals as it relates to your health and safety.

Name: ______________________ UCID #: ______________

Sex: O Male O Female Date of Birth: ____ / ____ /____
Month/Date/Year

UC e-mail address: ______________________

Current address: ______________________
Street Address *City* *State* *Zip*

Local Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Name of program: ______________________

Location of program: ______________________

Dates of program: ______________________

This information is required to coordinate treatment in the event of a medical emergency. Answer "N/A" if not applicable.

ALLERGIES

Medical Allergy: Reaction: Treatment, if exposed:

____

____

____

Food or environmental allergy: Reaction: Treatment, if exposed:
(foods, dust, chemicals, household items, pollen, bee stings, etc.)

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____

MEDICATIONS

Please list any medicines you are taking on a daily, regular, or as needed basis, and indicate how often and why each medicine is taken.

Name of Medication: How often taken: For what condition: Length of time treated (approx.):

____

____

____

NOTE: Participants must bring an adequate supply of medications that are required on a daily or routine basis when traveling abroad.

DIETARY RESTRICTIONS

Do you have any dietary restrictions? O Yes O No

If yes, please explain: ______________________

____

Return this form to the University Honors Program

DISABILITIES

Are you registered with UC Disability Services? (If you think you may be eligible, contact them in 210 University Pavilion, 513-556-6823.)

O Yes

O No

Do you have a disability that will require accommodations while participating in this program?

O Yes

(If you do not disclose your disability and/or request accommodations in a timely manner, UC may not be able to assess and accommodate your needs.)

O No

ADDITIONAL HEALTH CONDITIONS

Do you have any additional health conditions other than those previously listed (such as surgeries, hospitalizations, significant injuries, chronic conditions, physical illness, psychological illness, emotional illness, etc.) that may need special consideration before or during your experience or that may affect your ability to participate in this program?

O Yes O No

If yes, you are advised to consult with your health care provider. Please supply an explanation below:

Condition(s):	How often do you have symptoms?	Plan for managing this condition while traveling:

HEALTH AND EMERGENCY AGREEMENT

I authorize the release of information contained in this Student Health/Emergency Treatment Authorization form for access and review by the advising staff of the University Honors Program, relevant faculty directors and the appropriate health professionals in the UC Health Services. I understand that if I have not turned in this form in a timely manner, there may be insufficient time for the directors to review this information. If further medical information is required, I understand that I will be contacted by a health care professional in UC Health Services who will ask for a specific release form to my treating health care professional(s), and/or clarify medical information with me directly. I understand that if this information is pertinent to my health and safety, it may be discussed in a confidential manner with the University Honors Program staff, faculty, or other program staff (such as on-site professionals).

In the event that I need emergency medical care, hospitalization, or surgery while participating in the program, I authorize the University of Cincinnati, through its representatives, to secure any necessary treatment. In some cases, access to medical care and services may be limited. If coverage is not provided through the local program provider, I understand that such treatment shall be soley at my expense, and I shall reimburse the University of Cincinnati or its representatives for any expenses that they might incur on account of my condition or treatment. In the event of any emergency abroad, the University of Cincinnati may notify my emergency contact listed on the Emergency Information form.

I certify that all responses made on this form are complete, true and accurate, and I understand that if there are any changes in my health status, I will complete and submit an updated Student Health/Emergency Treatment Authorization. I understand that if I withhold information on this form I could be withdrawn from the program. If I am sent home for reasons related to withheld information, I will be responsible for all incurred costs. I understand that participation in this program is contingent on receipt by the University Honors Program of this completed and signed form.

Participant Signature: ______________________________ Date: ______________

Parent/Guardian Signature (if under 18): ______________________________ Date: ______________

If you have any questions regarding medical problems, immunization requirements, or other health issues, call the University Health Services at least 45 days prior to the start of the program.

To make an appointment call:
East Campus, Holmes Building, 1st floor 513-584-4457
West Campus, Lindner Athletic Center, 3rd floor 513-556-2564