# DAAPcamp medical authorization form



UNIVERSITY OF Cincinnati

COLLEGE OF
**DESIGN**
**ARCHITECTURE**
**ART**
**PLANNING**

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**NOTES & INSTRUCTIONS**

*This form must be completed and returned by* ***June 01, 2014.*** *It can be submitted online or mailed to the address listed above.*

*All questions about the Design DAAPcamp should be directed to daapcamps@uc.edu or 513-556-2958.*

*student name*

*grade level (for the 2014-2015 academic year)* *age (as of 6/15/14)* *date of birth*

○ *male* ○ *female*

*parent/guardian name* *parent email*

*home address* *city* *state* *zip*

*home phone number* *alternative phone number*

*employer name*

*employer address* *city* *state* *zip*

*If student is to be picked up by someone other than parent/guardian, indicate that person's name, relationship to the student, and phone number below.*

*name* *relationship* *phone number*

*Is the student on special medication, or does the student have a medical condition about which we should be aware?* ○ *yes* ○ *no*
*If you answered yes, please explain why on the following two lines.*

*Physician Name* *Phone Number*

*Dentist Name* *Phone Number*

*Does the student have family/hospital insurance?* ○ *yes* ○ *no*

*Insurance Carrier Name* *Carrier Phone Number* *Policy/Group Number*

***Parent Authorization***

I hereby give DAAPcamps and its agents thereof permission to contact an emergency hospital or physician to provide treatment for my child in the event that I cannot be reached during an emergency.

*parent/guardian signature* *date*

*parent insurance policy/group number*