VATICAN ADVANCED TECHNOLOGY TELESCOPE MEDICAL RELEASE

please print all information; continue on back side if necessary

STUDENT:

Full name: _____

Birth date: _____

Present health: _____

Past injuries: _____

MEDICATIONS:

Drug allergies & sensitivities: _____

Date of last tetanus booster: _____

Are immunizations up-to-date? **YES** or **NO** (If NO, please explain on back of this form)

Medications (prescription & over-the-counter) student will require while observing at VATT:

List kinds and frequencies: _____

_____

DIETARY:

Restrictions: _____

Food allergies: _____

If "vegetarian," please elaborate (vegan?; do you eat dairy, fish, chicken?): _____

HEALTH INSURANCE:

Is student covered by health insurance? YES or **NO**

Please attach photocopies of both sides of your insurance card or claim form.

Company _____

Policy number _____

Address _____

City _____ State _____ Zip _____

LIST ALL medical conditions, motion sickness, physical disabilities, and any emotional or behavioral problems:

I agree to let my child be treated by a licensed physician while observing at VATT, as may be necessary, and to assume all costs related to such treatment. I authorize my insurance company to pay benefits to any medical facility or hospitals. Also, I authorize the disclosure of medical information to my insurance company for the purpose of claim. The above student has my permission to take the medications listed above as needed during the observing run.

Parent's Signature _____ Date _____

Street Address _____

City _____ State _____ Zip _____

Phones: (Home) _____ (Work) _____ (Cell) _____

Emergency contact (other than parents): _____