

NASA/STEP PROYECTO ACCESS PROGRAM
500 Grand Concourse B-420
Bronx, NY 10451

MEDICAL HISTORY FORM

The following information is needed to alert the *NASA/STEP Proyecto Access Program* staff of any health related situations that may arise and to provide information to medical personnel in the event of an emergency.

STUDENT'S NAME _____ BIRTHDATE _____

PARENT'S NAME _____ HOME PHONE _____

ADDRESS

NUMBER	STREET	BOROUGH	ZIP CODE
--------	--------	---------	----------

WORK PHONE: MOTHER () _____ FATHER () _____

NAME OF STUDENT'S PHYSICIAN _____

PHYSICIAN'S TELE PHONE () _____

IF UNABLE TO CONTACT PARENT(S), WHO SHOULD WE CONTACT?

NAME _____ PHONE () _____

MEDICAL HISTORY

SERIOUS ILLNESSES:

SURGERIES:

ALLERGIES (TYPE AND REACTION):

BLOOD TYPE _____

EYEGASSES: YES OR NO

CONTACT LENSES: YES OR NO

INDICATE ANY HEALTH-RELATED MATTERS OF WHICH *NASA/STEP Proyecto Access Program* OUGHT TO BE AWARE.

PARENTAL PERMISSION

TO THE BEST OF MY KNOWLEDGE, THE *NASA/STEP Proyecto Access Program* MEDICAL FORM IS CORRECT, AND
NASA/STEP Proyecto Access Program STUDENT HEREIN DESCRIBED, HAS PERMISSION TO ENGAGE IN ALL
PRESCRIBED ACADEMIC OR RECREATIONAL ACTIVITIES, EXCEPT AS NOTED BY ME ABOVE.

PARENT'S SIGNATURE

DATE

**NASA/STEP Proyecto Access Program
500 Grand Concourse B-420
Bronx, NY 10451**

Medical Emergency Consent

STUDENT'S NAME _____ BIRTHPLACE _____

ADDRESS _____
NUMBER STREET BOROUGH ZIPCODE

Phone number () _____

I, _____, HEREBY GIVE MY CONSENT TO HAVE MY CHILD
(NAME OF PARENT)

TAKEN TO A LOCAL HOSPITAL ACCOMPANIED BY A MEMBER OF THE NASA/STEP *PROYECTO ACCESS PROGRAM* STAFF AND TO HAVE MEDICAL STAFF ADMINISTER THE NECESSARY MEDICAL TREATMENT AND/OR NECESSARY X-RAYS TAKEN THAT HE OR SHE MAY NEED IN CASE OF EMERGENCY.

I UNDERSTAND THAT EVERY EFFORT WILL BE MADE BY THE STAFF OF THE NASA/STEP *Proyecto Access Program* TO CONTACT PARENTS, FAMILY PHYSICIAN, AND THE EMERGENCY NUMBER LISTED BELOW. IF YOU HAVE MEDICAL INSURANCE, PLEASE INDICATE THE INSURANCE COMPANY, POLICY NUMBER, AND THE NAME OF THE POLICYHOLDER. ALSO LIST AN EMERGENCY TELEPHONE NUMBER.

INSURANCE COMPANY AND POLICY NUMBER _____

NAME OF POLICYHOLDER _____

EMERGENCY TELEPHONE NUMBER _____

PARENT'S SIGNATURE

DATE

IN AN EMERGENCY, PLEASE CONTACT THE FOLLOWING PERSON(S) IF PARENT(S) CANNOT BE REACHED AT THE TIME.

NAME/RELATIONSHIP TELEPHONE NUMBER(S) (HOME/WORK)

1. _____ () _____ / () _____

2. _____ () _____ / () _____

3. _____ () _____ / () _____