



University of New Mexico Health Sciences Center
Research Experience for High School Students
Medical Information and Parental Consent Form

A medical provider will need this form before treating a participant's illness or injury.

Name of Student: _____ DOB: _____

Name of Parent(s) or Legal Guardian(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Primary Insurance Carrier: _____ Insured Name: _____

Group or Policy Number: _____

Emergency Contact Primary: _____ Secondary: _____

Primary Phone: _____ Secondary Phone: _____

If the student has any condition that may require special treatment it is imperative that a medical provider is alerted. Please indicate below any on-going medical or emotional problems that may require special attention (e.g., epilepsy, allergies, asthma, disability, anxiety, depression, etc.). Use reverse side if necessary. _____

Has the student had any major illness during the past year? _____ If yes, please explain: _____

Does the student take any prescribed medications? If yes, please explain: _____

Does the student have any allergies to medicines or food? If yes, please explain: _____

Primary Care Physician: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Parent or Guardian Read and Sign: I hereby certify that to the best of my knowledge the above medical statement is accurate. I give my consent to the UNM faculty/staff member to have my son/daughter treated by medical personnel for any illness or sickness that may occur while my son/daughter is at your facility. It is also understood that I will be notified before any major surgery or treatment will be administered except in an extreme urgency when the delay will constitute a serious risk to the life of my son/daughter. I further realize that expenses for medical attention shall be my responsibility.

(If student is under 18) Parent/Guardian: _____ Date: _____

Student: _____ Date: _____