PARTICIPANT MEDICAL INFORMATION & EMERGENCY AUTHORIZATION

For use by STEM-U or as a sample template for a school, homeschool group, Scout group, or other sponsoring organization. Review and adapt to the program's policies and applicable law.

TRIP & PARTICIPANT INFORMATION		
Trip/Program: _____	**Destination(s):** _____	**Travel Dates:** _____
Participant Full Legal Name: _____		**Date of Birth:** _____
Home Address: _____		
PARENT/GUARDIAN & EMERGENCY CONTACTS		
Parent/Legal Guardian: _____	**Relationship:** _____	**Mobile Phone:** _____
Email: _____		
Second Emergency Contact: _____	**Relationship:** _____	**Mobile Phone:** _____
Email: _____		
HEALTH INSURANCE & HEALTH CARE PROVIDER		
Insurance Company: _____	**Member/Policy ID:** _____	**Group Number:** _____
Primary Insured: _____		**Insurance Phone:** _____

Primary Health Care Provider:	**Provider Phone:**
_____	_____

MEDICAL INFORMATION

Allergies (medications, foods, insects, environmental; include reaction and severity):

_____

_____

Current medical conditions, diagnoses, injuries, disabilities, accessibility needs, or activity restrictions:

_____

_____

Medications (name, purpose, dose, schedule, and storage requirements; attach additional instructions if needed):

_____

_____

Medication plan while traveling (self-carried/self-administered, held by STEM-U or sponsoring-organization personnel, or reminders/assistance required):

_____

Emergency medications carried:	**Location/carrier:**
□ Epinephrine auto-injector □ Inhaler □ Other: _____	_____

Dietary restrictions or medically required diet:

_____

Sleep-related needs, including sleepwalking or other safety concerns:

_____

Blood Type (if known): _____	**Other information important in an emergency:**
	_____

EMERGENCY MEDICAL AUTHORIZATION

I confirm that the information provided on this form is accurate and complete to the best of my knowledge. I authorize designated STEM-U personnel or the sponsoring organization's trip leaders, together with emergency responders, to obtain and consent to emergency evaluation, first aid, transportation, and medical or dental treatment for the participant when necessary and when I cannot be reached promptly. This authorization includes diagnostic procedures, medication, anesthesia, hospitalization, and surgery when recommended by a licensed health care professional. I understand that treatment decisions remain with licensed providers and that I am responsible for costs not covered by insurance. I will promptly provide written notice of any change in the participant's health, medication, restrictions, or emergency contacts before departure.

Preferred Hospital/Health System, if any: _____ **Religious, cultural, or other treatment considerations:** _____	
Important: Attach copies of the participant's current insurance card and any written emergency action plan or medication instructions required by STEM-U or the sponsoring organization. Do not place original identity documents in this form.	
Parent/Legal Guardian Signature: _____ _____	**Date:** _____
Printed Name: _____	**Best Phone During Travel:** _____ _____