University of California, Irvine  
School of Engineering FABcamp  
MEDICAL RELEASE FORM

Student Name __________________________  School __________________________  Grade ____________

Is the student listed above allergic to any medication?  YES (     ) NO (     ) If yes, please explain: __________________________________________

Are there any existing medical problems?  YES (     ) NO (     ) If yes, please explain: __________________________________________

Are there any pre-existing conditions that we should be aware of?  YES (     ) NO (     ) If yes, please explain: __________________________________________

Family Doctor __________________________________________  (___) ___________________  Telephone __________________________

If I am unable to be reached, call __________________________________________  (___) ___________________  Name of Relative or Friend  
Must be an adult other than the parent/guardian  

(_____) ___________________  Name of Relative or Friend  
Must be an adult other than the parent/guardian  

PERMISSION FOR EMERGENCY TREATMENT:
In the event of accident, illness or injury during, or as a result of my child's participation in FABcamp, I hereby authorize University personnel to obtain for my child any medical or emergency treatment they may deem appropriate. I hereby authorize any physician, hospital or other healthcare provider to undertake any and all treatment and/or tests, including but not limited to radiographic examinations (e.g. x-rays, CT Scans, MRI scans, etc), laboratory tests (including the obtaining of blood and/or urine specimens), the providing of oral or intravenous medications, etc which said health care provider(s) believe, in the exercise of their professional judgment, is required to diagnose and/or treat my child's condition. I agree that the University is no way responsible for any medical care my child receives pursuant to this paragraph, and hereby agree to hold the Regents of the University of California, their agents and employees, harmless for any medical care or treatment my child receives pursuant to this paragraph. I further acknowledge that I alone am financially responsible for any costs or fees incurred or associated with the provision of any medical care to my child pursuant to this paragraph.

Parent / Legal Guardian Signature __________________________  Print Parent / Legal Guardian Name __________________________  Date ________

Home Phone: ________________________  Cellular Phone: ________________________  Work Phone: ________________________