



Institute of Technology

1 Castle Point on Hudson  
Hoboken, NJ 07030

**EDUCATIONAL OPPORTUNITY FUND  
MATHEMATICS IMMERSION PROGRAM  
MEDICAL INFORMATION AND TREATMENT AUTHORIZATION FORM**

This information is required to enable the Health Services Office at Stevens Institute of Technology to provide you with medical care during your participation in the Mathematics Immersion Program (MIP). All information in your medical record is confidential and will not be released without your written permission.

**Please type or print clearly, and answer all questions.**

**Part A: Identification Information**

Name: \_\_\_\_\_  
Last First M.I.

Sex: M \_\_\_\_\_ F \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address: \_\_\_\_\_  
No. Street Apt #/Suite# Floor

\_\_\_\_\_ City State Zip

Phone #: (\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_  
A/C A/C

Authorization for Medical Treatment

This authorization is provided in connection to my participation in the MIP summer program. I certify that I have provided Stevens with all the information relating to any health condition, which would require a special accommodation, medication or medical treatment. I hereby authorize Stevens personnel to furnish or arrange to furnish such minor medical care I may require. I also authorize emergency treatment in the event of serious illness or injury.

I agree to hold Stevens, its trustees, officers, employees, and agents harmless from any claims, liabilities or costs associated with providing medical care or treatment. I further agree that neither Stevens nor its trustees, officers, employees or agents shall be legally liable for any injuries, damages or other costs incurred by me as a result of Stevens providing, securing or administering medical treatment or care to me.

I certify that I have read the above carefully.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please complete Part B of this form.**

# REPORT OF MEDICAL HISTORY

Name \_\_\_\_\_  
Last First

PERSONAL HISTORY Do you now have or have you ever had:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Hearing Aid(s)                     | <input type="checkbox"/> Recent weight gain or loss<br>How much _____ lbs.                                |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Heart Problem/Murmur               | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hepatitis                          | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Alcohol/Drug Abuse     | <input type="checkbox"/> High Blood Pressure                | <input type="checkbox"/> Sinusitis  |
| <input type="checkbox"/> Back Problem           | <input type="checkbox"/> Infectious Mononucleosis           | <input type="checkbox"/> Skin Disorder  |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Kidney Problems                    | <input type="checkbox"/> Tonsillitis (Chronic)  |
| <input type="checkbox"/> Chronic Fatigue        | <input type="checkbox"/> Learning Disability                | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Lyme Disease                       | <input type="checkbox"/> Ulcer  |
| <input type="checkbox"/> Eating Disorder        | <input type="checkbox"/> Malaria                            | <input type="checkbox"/> Unexplained Aches & Pains  |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Meningitis                         | <input type="checkbox"/> Use smokeless/chewing tobacco  |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Migraine/Frequent Severe headaches | <input type="checkbox"/> Smoke cigarettes, cigars or pipe<br>How many years _____<br>How many a day _____ |
| <input type="checkbox"/> Fainting Spells        | <input type="checkbox"/> Muscle Disorder                    |   |
| <input type="checkbox"/> Frequent Cough         | <input type="checkbox"/> Night Sweating                     |   |
| <input type="checkbox"/> Glasses/Contact Lenses | <input type="checkbox"/> Psychological/Emotional Issues     |   |
| <input type="checkbox"/> Head Injury/Concussion |   |   |

Do you now have or have you ever had :

- Suicide attempts                       An abusive/controlling relationship     Sleep difficulties

If yes, please comment \_\_\_\_\_  
 \_\_\_\_\_

Other medical conditions that you believe we should be aware of? (please explain) \_\_\_\_\_  
 \_\_\_\_\_

List any allergies: \_\_\_\_\_

Have you ever been hospitalized?\_\_\_\_\_ Had any operations? (please note details) \_\_\_\_\_  
 \_\_\_\_\_

List all current medications \_\_\_\_\_

List any serious injury \_\_\_\_\_

## FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER(S)					
SISTER(S)					

Has any of your immediate family ever had any of the following: (Please state relationship)

- |  |  |
|--|--|
| <input type="checkbox"/> Alcohol/Drug Abuse Issues _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cancer _____                    | <input type="checkbox"/> Kidney Problems _____     |
| <input type="checkbox"/> Diabetes _____                  | <input type="checkbox"/> Tuberculosis _____        |
| <input type="checkbox"/> Heart Disease _____             | <input type="checkbox"/> Other _____               |

I hereby certify that the information submitted on this record is complete and correct.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_