

Auburn University  
School of Forestry and Wildlife Sciences

**Personal Medical Record Form**  
**Summer Practicum**

**Please Print All Entries**

Name \_\_\_\_\_ Student ID # \_\_\_\_\_  
Last First Middle

Auburn Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Permanent Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

1. \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone Number \_\_\_\_\_

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

2. \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone Number \_\_\_\_\_

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

1. In the space provided below, please make us aware of any medical conditions that may need to be taken into account during an extended experience like Practicum. For example, it would be helpful for us to know if you are prone to severe reaction to insect bites or stings, asthma, pollen or medicinal drugs, or may be subject to seizure disorders, diabetes side-effects, heart conditions, or other conditions that may require prompt, specialized attention. We need to be prepared to provide this information to medical personnel in case you are incapacitated and unable to provide it personally. The health care providers asked to review this form have suggested that students having life-threatening allergies or conditions also wear a **Medic Alert** bracelet. This assures that medical personnel are readily made aware of vital information.

If you develop a non-disabling medical problem or injury between the time you submit this form and the beginning of Practicum, please inform the Practicum Director promptly so appropriate attention can be afforded you.

2. IMMUNIZATIONS: Tetanus \_\_\_\_\_  
(Date)

All statements above are true to my knowledge. I understand that information provided will be kept strictly confidential and will be revealed only to those individuals with a specific need to know. I give my permission for such diagnostic, therapeutic and operative procedures as may be deemed necessary by a physician providing emergency care.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
(Summer Practicum Student)

I give permission for such diagnostic, therapeutic or operative procedures as may be necessary for my son/daughter. (Where practical you will be notified by telephone before any procedures are done.) **Parental signature is not required if student is nineteen (19) years of age or older.**

Date \_\_\_\_\_ Signed \_\_\_\_\_  
(Parent or Guardian)

*Please complete and return this form for receipt by April 3, 2017 to:*

**Attn: Lisa Hollans  
Office of Student Services  
School of Forestry and Wildlife Sciences  
602 Duncan Drive Room 2223  
Auburn, AL 36849-5418**