

**XAVIER UNIVERSITY**  
**Club, Team, Group or Academic Class On- and Off-Campus Activities**  
**Emergency Medical Care Authorization and Health History**

Occasionally a Xavier faculty member, employee or student (an “XU Individual”) participating in on- or off-campus activities with a Xavier club, team, group or academic class may face a health emergency requiring local hospitalization or emergency treatment. I authorize Xavier University, through its representatives, to secure emergency medical care, hospitalization or surgical treatment or dental treatment for me during my participation in these On- or Off-Campus Club, Team, Group or Academic Class Activities.

In the event of a medical emergency, Xavier University, through its representatives, will make every effort to reach the person or persons designated below:

FIRST EMERGENCY CONTACT

SECOND EMERGENCY CONTACT

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship \_\_\_\_\_

Relationship: \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone (day): \_\_\_\_\_

Telephone (day): \_\_\_\_\_

Telephone (evening): \_\_\_\_\_

Telephone (evening): \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Certificate of Medical Insurance Coverage**

Xavier University requires that all students and recommends that all faculty members and employees have insurance with medical coverage while participating in On- or Off-Campus Club, Team, Group or Academic Class Activities. By signing below, I certify that I understand Xavier University is not required to pay for any of my medical costs while I am participating in these Activities beyond that which is provided to me as a benefit of my employment (if applicable). I further understand that Xavier University is not required to pay for any evacuation, reunion or repatriation of remains costs that arise out of my participation in these Activities.

I certify that I will be covered by medical insurance with this type of coverage valid during the time that I participate in these Activities, or that I understand and fully accept any and all consequences of not being covered by such insurance during my participation in these Activities.

XU Individual’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent’s or Guardian’s Signature (if student is under age 18): \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of XU Individual: \_\_\_\_\_ XU Banner ID: \_\_\_\_\_

Insurance Company (if applicable): \_\_\_\_\_ Policy Number (if applicable): \_\_\_\_\_

**PLEASE ATTACH A COPY OF YOUR INSURANCE CARD, FRONT AND BACK**

A copy of this form will be kept at Campus Police and with the sponsoring department. The original should be taken by the Activity organizer participating in the particular Activity.

**This is the only form approved by Xavier University for this purpose.**  
**It may not be modified or changed in any way.**

### HEALTH HISTORY

The following information concerning medical history, including allergies, medications being taken, and physical impairments, to which a physician should be alerted:

#### GENERAL INFORMATION

\_\_\_\_\_ ( ) Male ( ) Female  
(LAST NAME) (FIRST) (MIDDLE) (BIRTH DATE)

PERMANENT MAILING ADDRESS:

\_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

**HEALTH PROBLEMS** – List any continuing health problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DRUG ALLERGIES AND REACTION** – List any drug allergies and briefly describe what happened:  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICINES** – List any medicines, pills or injections (prescription and over-the-counter) you take regularly: \_\_\_\_\_  
\_\_\_\_\_

**HISTORY** – Check if you have ever had any of the following:

_____	Anemia	_____	Heart problems (describe)
_____	Asthma/hay fever/allergy	_____	Jaundice/hepatitis
_____	Back problems	_____	Protein/sugar in urine
_____	Bladder/kidney problem	_____	Surgery _____ (TYPE AND YEAR)
_____	Epilepsy/convulsions	_____	Emotional/Mental problems
_____	High blood pressure	_____	Drug/Alcohol problems
_____	Ulcer/stomach problem		

\_\_\_\_\_ Have you ever lived in close contact with anyone who had tuberculosis?  
TB skin test: \_\_\_\_\_ negative \_\_\_\_\_ year TB Medicines Taken: \_\_\_\_\_  
\_\_\_\_\_ positive \_\_\_\_\_ year \_\_\_\_\_  
\_\_\_\_\_ never tested

Anything else that we should be aware of? \_\_\_\_\_

#### FAMILY MEDICAL HISTORY

Has anyone in your family had any of the following problems?

_____	Asthma/hay fever	_____	High blood pressure
_____	Diabetes	_____	Sickle cell/anemias
_____	Heart disease		

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