

March 26, 2019

Dear Summer Student,

Welcome to the Upward Bound 2019 Summer Program at Southern Arkansas University. The summer program will begin June 9, 2019 and conclude July 19, 2018. Only students currently in the 10th and 11th grades will be allowed to attend the summer program.

Before the summer program begins, parents/guardians and students will need to attend an orientation to discuss Upward Bound expectations. Orientation helps to ensure the safety of students and the success of the summer program. The Parent/Student summer orientation will take place on May 13, 2019 at 6:00 -7:30 p.m. in Foundation Hall, which is located in the Donald W. Reynolds Center on the SAU campus. This orientation is mandatory for all parents/guardians and students attending the Upward Bound summer program.

The attached summer registration packet must be completed and returned to the Upward Bound program prior to April 10, 2019 for Wednesday students and April 6th for Saturday students. It is important that the correct classes are scheduled and t-shirts sizes are ordered well before the start of the summer program, which is why it is imperative that we receive the packet on the above dates.

If you have any questions or concerns or are unable to make the orientation on May 13, 2019, please call the Upward Bound office at 870-235-4160 to make other arrangements. As always, we look forward to working together to ensure the success of each Upward Bound student.

Sincerely,

Carla Williamson

Director

2019 Summer Survey

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate whether or not you plan to attend Upward Bound this summer:

❑ Yes

❑ No

If no, please indicate the reason. If the student is attending any

Camps this summer, please provide documentation of this.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, indicate T-shirt size:

❑ Small

❑ Medium

❑ Large

❑ X-Large

❑ 2X-Large

❑ 3X-Large

❑ 4X-Large

If yes, indicate your choice(s) for roommate:

1st Choice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Choice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3rd Choice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUIRED MEDICAL HISTORY & CONSENT FOR TREATMENT – ALL CAMPS**

Camp child will be attending: **UPWARD BOUND Dates: June 9 thru July 19, 2019**

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_ Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

M phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PM phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF EMERGENCY, if parent cannot be reached, names of person to notify or to whom we release child: Name(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AM phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PM phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**UNDER NO CIRCUMSTANCES SHOULD CHILD BE RELEASED TO**:\_\_\_\_\_\_\_\_\_

**CIRCLE ALL CHILD HAS OR HAS HAD:**

Constipation Bed Wetting Sleepwalking Swimmer’s/Abscessed ear Mumps

Convulsions Homesickness Asthma Frequent Colds Nausea

Tuberculosis Chicken Pox Heart Trouble Scarlet Fever Polio

Diabetes Measles Bronchitis Appetite Loss Sinusitis Glasses Contacts Kidney Trouble Frequent Sore Throat Rheumatic Fever

Of the above, these are current or recurring:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:** bee stings\_\_\_\_ drugs\_\_\_\_\_ foods\_\_\_\_\_\_ other\_\_\_\_\_\_

Recently exposed to contagious disease? Y or N If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Following three questions are for females only:**

Menstruates? \_\_\_\_Yes \_\_\_\_No

Menstruation normal? \_\_\_\_Yes \_\_\_\_No If no, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If does not menstruate, student knows about it? \_\_\_\_Yes \_\_\_\_No

Has the student been hospitalized within past 5 years? \_\_\_\_Yes \_\_\_\_No

If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe physical conditions requiring restrictions for participating in camp programs

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being treated by a physician? \_\_\_\_Yes \_\_\_\_No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUIRED MEDICAL HISTORY & CONSENT FOR TREATMENT – ALL CAMPS**

Upward Bound Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Insurance Company’s address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family’s Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Insurance Company’s address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent’s Insurance Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A copy of the student’s immunization records are required by the Department of Public Health**

(Immunization records **must** be attached with summer packet)

**Consent for Emergency Medical Treatment or Counseling Services:**

*I do hereby give authority to adult staff to obtain or provide necessary emergency medical treatment or counseling services for my child in the event of an unforeseen crisis with the understanding that the family will be notified as soon as possible.*

Print Parent/Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescription and Over-the-Counter Medication Policy:**

* Prescription medications that are controlled substances will be dispersed by the University Health Services.
* When University Health Services is closed, the Upward Bound Hall Director or Assistant Hall director will dispense medications.
* Prescription medications that are controlled substances will be counted by the RN and a witness upon receipt, and counted again by the RN and a witness at the time of transfer of the medication back to the camp director.
* All medications dispensed by the University Health Services will be documented on a medication log
* Person(s) to administer medication and any needed care when the University Services offices closed:
  + - Residence Hall Director
    - Assistant Hall Director
    - Residence Hall Staff

**In Case of an Emergency, notify: (please print)**

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Business Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**It is highly important that this form is completed in its entirety. Copies of these records are given to the University Health Services for the benefit of your child while he/she is on the Southern Arkansas University campus.**

**2019 Fall Classes**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade level\_\_\_\_\_**

Please list or attach a class schedule for classes that you are enrolled to attend in the Fall of 2018.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle the extracurricular class you are most interested in attending:

ART DRAMA DANCE

**2019 Over the Counter**



**Medication Administration**

Upward Bound

Southern Arkansas University

This is to verify that, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a student at the Upward Bound 2017 Summer Component has my permission to take or have administered to him/her the following OTC (over the counter) medication by the University Health Services, the Upward Bound Staff, or the Residence Hall Staff.

Student **CAN** be administered the following OTC medication

(Check all that apply):

**Pain/ Fever**

**Anti-histamines/ Anti-Itch**

**Antacids/**

**Anti-diarrheal**

\_\_\_\_\_Tylenol \_\_\_\_\_ Benadryl \_\_\_\_\_ Gas-X

\_\_\_\_\_ Ibuprofen \_\_\_\_\_ Hydrocortisone \_\_\_\_\_ Maalox

\_\_\_\_\_ Aleve \_\_\_\_\_ Calamine \_\_\_\_\_ Tums

\_\_\_\_\_ Aspirin \_\_\_\_\_ Caladryl \_\_\_\_\_ Pepcid AC

\_\_\_\_\_ Advil \_\_\_\_\_ Pepto-Bismol

\_\_\_\_\_ Excedrin ­\_\_\_\_\_ Imodium AD

\_\_\_\_\_ Motrin

\_\_\_\_\_ Midol/ Pamprin

Other/ Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Name **(Please PRINT)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/ Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_