

PRAIRIE WIND FESTIVAL HEALTH FORM

Health Services

The Student Health Service of the University of Kansas at Watkins Health Center provides health services for students enrolled in the Prairie Wind Festival. The scope of medical care is identical to that provided for regular students of the University. Our staff consists of full-time physicians and other professional personnel. Services of the Health Center are of high quality and provide care for most health needs of students. Watkins Health Center is open from 8:00 a.m. until 8:00 p.m., Monday through Friday, and 8:00 a.m. until 4:30 p.m. on Saturday, and 12:30 p.m. until 4:30 p.m. Sunday. Of course emergency care at any time is available at the Emergency Room of Lawrence Memorial Hospital.

Costs for these services are charged to the patient, parent, or their insurance.

Our experience has shown that it is highly desirable that we have a background health record on each student and we appreciate you furnishing the information requested on the reverse side of this sheet so that the Prairie Winds staff can bring it in with student if the need arises.

A witness that is at least 18 years of age must sign the form.

Please do not hesitate to contact us at any time if you have any questions, or if we can be of service to you. We join everyone at the University of Kansas in extending our warmest best wishes to you for a happy and rewarding session at the Prairie Wind Festival.

Watkins Health Center
Student Health Services
The University of Kansas
Lawrence KS 66045-8830
(785) 864-9500

**PLEASE TURN THIS FORM IN TO THE PRAIRIE WIND FESTIVAL STAFF AT
REGISTRATION WHEN YOU ARRIVE.**

(Health Form on Reverse Side)

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124 MURPHY HALL, 1530 NAISMITH DR. • LAWRENCE, KANSAS 66045-3102 • (785) 864-3367 • FAX: (785) 864-4717

Prairie Wind Festival
CONFIDENTIAL MEDICAL RECORD
(Please turn in at time of registration)

Student's Name: _____ Sex: ___ Birthdate: ___/___/___
Student's Social Security #: _____
Parent's Name _____ Parent's Social Security #: _____
Phone: () _____ - _____
Address: _____ City: _____ State: _____ Zip: _____

PERSON TO BE NOTIFIED IN EMERGENCY, IF OTHER THAN ABOVE:

Name _____
Phone: () _____ - _____ day () _____ - _____ Night
Address: _____ City: _____ State: _____ Zip: _____

NAME AND ADDRESS OF FAMILY DOCTOR

Doctor's Name _____ Phone: () _____ - _____
Address: _____ City: _____ State: _____ Zip: _____

1. Do you have any significant illness or disability? _____ If so, please explain _____
2. Please check if you have or have had any of the following:
_____ Measles _____ Diphtheria _____ Polio _____ Epilepsy
_____ Mumps _____ Rheumatic Fever _____ Tuberculosis _____ Diabetes
_____ Chicken Pox _____ Kidney Trouble _____ Asthma _____ Fainting
3. Have you had any other significant illnesses, injuries, or surgeries? YES NO
If so, please explain: _____
4. Please give date of most recent immunization:
Tetanus _____ Smallpox _____ Diphtheria _____
Typhoid _____ Polio (oral) _____ Other _____
5. Are you allergic to any medication? YES NO Any other allergies? YES NO
If so, please explain: _____
6. What routine medications & dosages does the student take? _____

HEALTH INSURANCE BILLING INFORMATION

Name of company: _____ Claim Form Address: _____

Policy Holder Individual ID # _____ Group # _____ Name of policyholder: _____
Address of policyholder: _____ City: _____ State: _____ Zip: _____

I hereby authorize Watkins Memorial Health Center to release to the above named insurance company, information from my medical record as needed in presenting my claim for benefits.

Student's signature _____ Date: _____
Parent's signature _____ Date: _____

I hereby give my consent for treatment of _____
First Middle Last Date of Birth

**This authorization covers any procedure, which may be deemed
advisable by the attending staff physician and/or consultant.**

Signature of person authorized to give consent for patient treatment:
Name _____ Relationship: _____
Witness _____ Date: _____

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