



KAPPA ALPHA PSI FRATERNITY INC.
ST. LOUIS ALUMNI CHAPTER
GUIDE RIGHT PROGRAM



MEDICAL AUTHORIZATION

STUDENT NAME _____

AGE _____

ADDRESS _____

DOES STUDENT HAVE ASTHMA? YES _____ NO _____
IF YES, PLEASE MAKE SURE STUDENT HAS MEDICINE AT ALL TIMES

IS STUDENT DIABETIC? YES _____ NO _____
IF YES, PLEASE MAKE SURE STUDENT HAS MEDICINE/SNACK

FOOD OR MEDICAL ALLERGY (PLEASE LIST THOSE WE SHOULD BE AWARE OF) _____

PLEASE LIST ANY OTHER MEDICAL CONDITION THAT THE KAPPA LEAGUE ADVISORS SHOULD BE
AWARE OF _____

PARENT AUTHORIZATION

I, _____ GIVE KAPPA ALPHA PSI FRATERNITY ADVISORS PERMISSION TO SIGN FOR
ANY EMERGENCY CARE MY CHILD MAY NEED WHILE THEY ARE TRAVELING SINCE I WILL NOT BE WITH
THEM. I WILL BE RESPONSIBLE FOR ANY ACTIONS AFTER THEY HAVE CONTACTED ME OR HAVE
ATTEMPTED TO CONTACT ME.

SIGNATURE _____ DATE _____

PHONE NUMBERS _____

OTHER EMERGENCY CONTACTS

NAME & NUMBER _____

PLEASE ATTACH A COPY OF STUDENT HEALTH INSURANCE CARD