EOP 1

EOP STUDENT INFORMATION AND CONSENT FORM

Students attending Binghamton University are generally considered independent adults, and parental consent for medical care for those under 18 years of age are not routinely required. However, if medical concerns arise during summer, this information is referenced by medical professionals responding to emergencies. Should any of this information change, please notify the EOP Office as soon as possible at 607-777-2361 or EOP@binghamton.edu

Student Information:

Student Last Name:_____	Student First Name:_____	Student Middle Initial:_____
B #:_____	Student Date of Birth:_____/_____/_____ (Month/Day/Year)	

STUDENT'S HEALTH INSURANCE INFORMATION (Required to fill in both company and policy number)

Company:_____	Policy #:_____

EMERGENCY CONTACT (Required to complete)

First Name:_____	Last Name:_____
Relationship to Student:_____	
Phone Number:_____	Alternative #:_____

CONSENT FOR MEDICAL/EMERGENCY TREATMENT AND RELEASE OF INFORMATION (Required to complete)

Should the need for medical attention arise, I the below signed , hereby authorize the medical staff upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment deemed necessary for the emergency care of

_____, during the Binghamton Enrichment Program, 7/5/25 – 8/2/25

(Student Name)

Additionally, I the below signed hereby authorize release of any health information pertinent to well-being and provision of care and treatment of the aforementioned student to the appropriate EOP professional staff. Consent regarding services received is for the purpose of ensuring adequate treatment and follow-up care. Health care professionals include, but are not limited to, providers at local hospitals/walk-in clinics, Decker Student Health Services Center, and the University Counseling Center, as well as others with pertinent information regarding my well-being.

*I understand that authorizing the aforementioned release is voluntary and not a condition for treatment, nor admission to Binghamton University. I have the right to revoke this authorization at any time, in writing, to the Educational Opportunity Program Office at Binghamton University.

Student Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

(If student is Under 18 yrs of age)

EOP 2

EOP MEDICAL NEEDS AND ALLERGY FORM

Student Information:

Student Last Name:_____	Student First Name:_____	Student Middle Initial:_____
B #:_____	Student Date of Birth:_____/_____/_____ (Month/Day/Year)	

MEDICAL NEEDS AND ALLERGY

Please list any **Medical needs** (for example: Asthma, Seizures, Epilepsy, ADHD, etc.):

_____

_____

_____

Please list any **allergies to food or medicine** as well as **dietary restrictions** (Be as specific as possible)

_____

_____

_____

Religious Observations

Please list any **Religious Observations** with Dates if applicable (for example: Fasting, daily prayer, religious holidays)

_____

_____

_____

Other Medical or Religious Concerns not listed above

_____

_____