MEDICAL AUTHORIZATION AND HEALTH HISTORY FORM

Brown University Pre-College Programs
Box T, Providence, Rhode Island 02912-9120
Tel 401-863-7900

NOTE: You may not participate in programs until this form has been received.

This form is utilized when students require medical care.

Information provided on this form will be made available to health care providers and Pre-College Program staff.

EMERGENCY CONTACT INFORMATION

In the event of an emergency, we will call the student's parent/guardian first as listed in the Participant Contact Information. If we cannot reach the parent/guardian, we will call the emergency contact as designated in the Participant Contact Information. Please be sure to inform our office of any changes during the program. **The emergency contact listed below must be accessible when the program or camp is in session.**

PARTICIPANT CONTACT INFORMATION

Participant is attending:

Sports Camps(s) Summer@Brown / Berklee STEM for Rising 9th & 10th Graders Leadership Institute/BELL (AK, FL, RI)
Summer On Location Programs (Washington D.C., Rome, Segovia) Pre-Baccalaureate/Visiting Undergraduate

Last Name_____ First Name_____ Date of Birth_____

Gender Male Female Self-defined _____ Participant Cell Phone_____

Home Address_____

City/State _____ Zip Code_____ Country_____

Parent/Guardian Name(s)_____ Phone _____

Emergency Contact Name _____Emergency Contact Relationship _____

Emergency Contact Phone_____

INSURANCE COVERAGE **Please indicate proof of health insurance coverage with a US carrier below.**

PRE-COLLEGE STUDENTS: If proof is not listed, you will automatically be enrolled in Brown's student health insurance plan for a $75 fee for the length of the program. This plan has limited coverage.

SPORTS CAMPERS: If proof is not listed, Campers must enroll in Brown's limited insurance policy for the duration of the camp. The cost of insurance is $25 per camp.

Insurance Carrier: _____Policy Number: _____

Carrier Address: _____

Carrier Phone: _____Name of Policy Holder: _____

AUTHORIZATION FOR TREATMENT FOR PARTICIPANTS UNDER 18 YEARS OF AGE

During the program, it may become necessary for a participant of a Brown University School of Professional Studies program to receive medical services on or off campus. In order to provide appropriate medical services under these circumstances, parental/guardian permission must be obtained in advance for all participants under the age of 18. The parent/guardian will be notified as early as possible of an illness or injury, informed of the situation, and consulted about important medical decisions. However, a serious accident or injury may require immediate action and/or treatment without prior notification to the parent/guardian.

PARENT/GUARDIAN AUTHORIZATION

I acknowledge that I have an obligation to provide the requested medical information to Brown University's School of Professional Studies or designee on the Medical and Immunization History Form prior to my child/ward's participation in the program and to disclose any injuries, or illnesses they may suffer or may have suffered subsequent to signing this form. I agree to assume all risks and hazards resulting from any undisclosed injuries or illnesses. Further, I authorize the Dean or designee, at any time during the program, to take such action deemed necessary or desirable for my child/ward's welfare when they are transported to a health care facility for treatment to be rendered to them under the general or special supervision of a nurse, dentist, physician, or surgeon licensed to practice in the State of Rhode Island.

a. When the nature and severity of the illness or injury requires treatment beyond the capabilities of Brown University Health Services, in the judgment of Health Services personnel; and/or
b. In the event of an accident or emergency requiring immediate medical attention and/or treatment.

I agree to assign the benefits of personal coverage of medical insurance for my child/ward to the appropriate providers of their medical care. In the event that appropriate medical coverage under my medical insurance plan is unavailable, insufficient, or denied with respect to treatment or services provided by child/ward, I hereby agree to assume all financial liability and responsibility of all expenses and costs associated with said transportation and/or treatment of their illness or injury.

In consideration of Brown University's allowing my child/ward to participate in the program and agreeing to intervene on my behalf to provide or make arrangements to provide medical assistance to them as needed, I agree to release and indemnify Brown University, including the Corporation, its Trustees, faculty, employees, staff, and other agents from all liability and responsibility for any claims, demands, actions, or other proceedings for any personal injury, accident damage, expenses, or other loss caused, suffered, or incurred by him/her or any other person or entity arising out of his/her participation in the Program.

I authorize Brown University mental health providers to respond to acute mental health needs and determine if a participant is psychologically able to remain in the program.

I acknowledge that I have read and understand the above statements and that if I am unable to do so, for whatever reasons, I have had them read to me and am confident that the individual so doing has read and/or translated the statements truthfully and in their entirety.

MEDICAL CARE AUTHORIZATION FOR ALL STUDENTS Please check one:

_____*For participants 18 years of age or older:*

I, the participant named above, authorize Brown University and/or its designee to provide medical care and treatment adjudged to be necessary for me.

_____*For participants under 18 years of age:*

I, the parent/guardian of the participant named above, authorize Brown University and/or its designee to provide medical care, counseling and psychological service, and treatment adjudged to be necessary for my child/ward named above.

***If participant is under 18 years of age, parental/guardian authorization is required. This form is valid for one year from the date signed below.**

Parent/Guardian Initials _____ Date _____

Participant Initials _____ Date_____

List all physicians providing medical care (i.e. Physician, Allergist, Psychologist, etc.)

Medical Provider Name	Specialty	Phone number

Is the participant receiving any kind of treatment for the following conditions? If yes, please provide additional information.

Y N

☐ ☐ Allergies to food and/or beverages: _____

☐ ☐ Allergies to things other than food and/or beverages: _____

☐ ☐ Uses an Epi-Pen

☐ ☐ Asthma: _____

☐ ☐ Diabetes: ☐ Type 1 ☐ Type 2

☐ ☐ Seizure disorder: _____

☐ ☐ Eating disorder

☐ ☐ Recent Surgery

☐ ☐ Heart Condition

☐ ☐ Neurological disorder

☐ ☐ Fainting or dizziness

☐ ☐ Sickle Trait

☐ ☐ Chronic or recurring illness

☐ ☐ Recent injury or infectious disease, including recent hospitalization

☐ ☐ Other (please specify): _____

☐ ☐ Is the participant currently taking medication? If yes, please include all over-the-counter, prescription, and vitamins/supplements.

_____

☐ ☐ Does the participant have any significant mental health history? If yes, please describe:

_____

☐ ☐ May the participant engage in all program activities, including sports (if not, please list restrictions both temporary and permanent):

_____

☐ ☐ Does the participant have any predisposing medical, psychological and/or physical, conditions which may require support/treatment? If yes, please explain:

_____

Y N

☐ ☐ Has the participant been hospitalized in the past 5 years? If so, please explain:

☐ ☐ Other medical Information pertinent to routine care and emergencies:

If you have medical concerns that should be brought to our attention, please contact Brown University Health Services at 401-863-3953 or email nursing@brown.edu.

If your student or camper will need any disability related accommodations or services (academic, housing, dining, accessibility, etc.), please contact Student and Employee Accessibility Services (SEAS) at SEAS-SPS@brown.edu or 401-863-9588 as soon as possible. Information about needs must be provided directly to SEAS in a timely way in order for accommodations or services to be in place.

I certify that all of the information provided in this form is accurate.

Parent/Guardian signature_____ Date_____

Participant signature _____ Date_____