

## Health and Insurance Information Form

(To be completed by Parent/Guardian)

Student's Name: \_\_\_\_\_

### HEALTH INFORMATION

Does the student have any food/medication/other allergies? If so, please list.

\_\_\_\_\_

Does the student have any mobility or vision difficulties? If so, please explain.

\_\_\_\_\_

Has the student been under any medical care within the past three months? If so, please explain.

\_\_\_\_\_

Explain any treatment the student has received currently or in the past for their physical, mental or emotional health.

\_\_\_\_\_

Is the student on a special diet? If so, please explain.

\_\_\_\_\_

Should the student be restricted in recreation? In what way?

\_\_\_\_\_

Is there anything else we should know about the student or any other special needs the student may have?

\_\_\_\_\_

### IN CASE OF EMERGENCY

First contact name: \_\_\_\_\_

Day phone (\_\_\_\_\_) \_\_\_\_\_ Night phone (\_\_\_\_\_) \_\_\_\_\_

Second contact name: \_\_\_\_\_

Day phone (\_\_\_\_\_) \_\_\_\_\_ Night phone (\_\_\_\_\_) \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

My student has health insurance (PLEASE INCLUDE A PHOTOCOPY OF INSURANCE CARD – FRONT AND BACK.)

Name of insurance carrier: \_\_\_\_\_

Policy or group number: \_\_\_\_\_

Name of policy owner (insured): \_\_\_\_\_

I assume full responsibility for payment of medical expenses that are not covered by my insurance and are incurred as a result of my child's participation in the Explore Your Future program.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

My student does not have health insurance.

I assume full responsibility for payment of medical expenses incurred as a result of my child's participation in the TechBoyz program.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH INFORMATION AUTHORIZATION

HIPAA Statement for Medical and Health Insurance Information:

Any authorization you provide to EYF and RIT regarding the use and disclosure of your child's medical and health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your child's medical and/or health information for the reasons you describe. Please note that EYF is required to retain and maintain records of your child's care until **September 30, 2022**.

I give permission for EYF staff and employees of Rochester Institute of Technology to use and/or disclose protected health and medical information about my child's medical or other health conditions in order to carry out necessary treatment.

Student's name (please print): \_\_\_\_\_

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian's name (please print): \_\_\_\_\_

Parent/guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_