Health and Insurance

(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 in the past for his/her physical, mental or emotional health.
_____________________________________________________________________________________

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

Should the student be restricted in recreation or swimming? In what way?
_____________________________________________________________________________________

Is there anything else we should know about the student or any other special needs he/she 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 the 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 Health Care Careers Exploration 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 Health Care Careers Exploration Program.

Parent/Guardian signature ___________________________________________ Date __________________________

Health Information Authorization

HIPAA Statement for Medical and Health Insurance Information:

Any authorization you provide to Health Care Careers Exploration Program 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 Health Care Careers Exploration Program is required to retain and maintain records of your child’s care until September 30, 2020.

I give permission for Health Care Careers Exploration Program 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.

Camper’s name (please print) ____________________________________________

Camper’s signature ___________________________________________ Date __________________________

Parent/guardian name (please print) ____________________________________________

Parent/guardian signature ___________________________________________ Date __________________________