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? (i.e. Mental Health)

________________________________________________________________________

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 Explore Your Future 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, 2023.

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: __________________