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, 2023.

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 _____