2019 UConn Pre-College Summer

Health History and Consent for Treatment

Instructions: This form is to be completed by a parent/guardian. The form may be typed on, or handwritten. Then, once completed and signed, upload to the student's enrollment profile. A completed form includes all information mentioned below, including **hand** signatures from both the parent/guardian and participant.

For questions regarding this form contact **UConn Pre-College Summer** at (860) 486-0149 or at pcs@uconn.edu

PARTICPANT LAST NAME:	PARTICIPANT FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH: ___/___/_____
HOME PHONE:	BIRTHPLACE/COUTNRY OF CITIZENSHIP:		SEX AT BIRTH: Male ___ Female ___ Other: _____
HOME ADDRESS:	CITY:	STATE:	ZIP CODE:
PARENT/GUARDIAN NAME:	WORK PHONE:	CELL PHONE:	
ADDT'L PARENT/GUARDIAN NAME:	WORK PHONE:	CELL PHONE:	
IF UNAVAILABLE IN AN EMERGENCY, PLEASE CONTACT:			
NAME & RELATIONSHIP TO PARTICIPANT:	WORK PHONE:	CELL PHONE:	
PERSONAL PHYSICIAN/HEALTHCARE PROVIDER			
PHYSICIAN NAME:	PHONE NUMBER:		
HEALTH INSURANCE INFORMATION			
INSURANCE COMPANY NAME:	ADDRESS:		
INSURANCE ID NUMBER:	GROUP NUMBER:		
GUARANTOR FULL NAME (primary policy holder i.e., mother, father, etc.):	GUARANTOR ADDRESS (street, town, state, & zip):	GUARANTOR DATE OF BIRTH: ____/__ __/_____	
Does your health insurance cover prescription medications? (please mark):		No	Yes

Proof of Insurance Coverage: All participants should be enrolled in health care insurance while attending the Program in the event of receiving medical services. For this reason, participants are required to carry a photo ID and health insurance card**. International participants** should confirm with their health plan provider that they will be covered internationally during their stay in the USA. If international participants are not covered, they will need to purchase coverage for the dates they will be attending the Program

PLEASE CHECK THE APPROPRIATE BOXED PER MEDICAL CONDITION:
NOTE: A participant's mental/physical health, as long as they are independently functioning, will not prevent them from attending UConn's Pre-College Summer Program. Faculty, professional staff and residential staff need to know of any health issues/concerns **so that we can accommodate your child/ward accordingly.**

NO	YES	(CHECK YES OR NO)
		ADHD (ATTENTION-DEFICIT HYPERACTIVITY DISORDER)
		ASTHMA
		ANXIETY DISORDER
		SOCIAL ANXIETY DISORDER
		DEPRESSION
		BIPOLAR DISORDER
		PANIC DISORDER
		CONVULSIONS/SEIZURES
		DIABETES (TYPE I OR TYPE II)

		PREVIOUS HOSPITALIZATION/SURGERY (EXPLAIN):		
		PREVIOUS INJURY (EXPLAIN):		
		PHYSICAL DISABILITY (EXPLAIN):		
NO	**YES**	**MY CHILD/WARD HAS/IS:**		
		ALLERGIES TO MEDICATION (LIST):		
		FOOD ALLERGIES (LIST):		
		OTHER ALLERGIES (LIST):		
		UNDER A PHYSICIAN'S CARE FOR THE FOLLOWING CONDITION:		
		ANOTHER MEDICAL CONDITION STAFF SHOULD KNOW OF:		
NO	**YES**	**MY CHILD/WARD IS CURENTLY TAKING MEDICATIONS:***		
		MEDICATION 1:	DOSAGE:	REASON:
		MEDICATION 2:	DOSAGE:	REASON:
		MEDICATION 3:	DOSAGE:	REASON:
		MEDICATION 4:	DOSAGE:	REASON:
		MEDICATION 5:	DOSAGE:	REASON:

*As stated in our Program policy, an onsite nurse will not be present to administer medication to participants. It is the participant's responsibility to secure and self-administer any necessary prescribed medications. The Program will not provide any medication or over-the-counter drugs.

CONSENT FOR TREATMENT

I hereby grant permission for UConn Health Urgent Care or other appropriately deemed medical services, and Program staff to provide my child/ward with appropriate medical and mental health services or access to these services. These services may include providing medications for treatment of illnesses/injuries. Program staff will provide access to these services, including arranging for emergency medical care as needed. In the case of a health or safety situation, UConn Health Urgent Care and other medical services may disclose information about participant medical records (including treatment, payment, healthcare operations, etc.) to appropriate University personnel, parents/guardians, and/or listed emergency contacts

Parents/guardians will assume financial responsibility for all expenses of such care. This authorization is given in advance of any such medical treatment and is given to provide authority and power on the part of the University of Connecticut to exercise its best judgment upon the advice of medical or emergency personnel.

In submitting this form, I, the undersigned, hereby certify that, to the best of my knowledge, the medical information furnished herein is true and complete.

I, the undersigned, acknowledge that I have read and understand this consent, and that any questions I have prior to signing this can be answered by calling Pre-College Summer at (860) 486-0149.

If I have any questions regarding medical services offered at UConn Health Urgent Care, I understand that any questions can be directed to UConn Health Urgent Care at (860) 487-9300.

Parent/Guardian Name (Print):	Relationship:	Parent/Guardian Cell Phone Number:
Participant signature: Date: ___/___/_____	Parent/Guardian Signature: Date: ___/___/_____	

PLEASE KEEP A COPY THIS HEALTH HISTORY FORM FOR YOUR RECORDS

Upload this completed and signed form to student's enrollment profile.
Click "Modify/Upload forms/Edit Travel" once logged in.