

MEDICAL AUTHORIZATION FORM



Brown University, Box 1946
Providence, Rhode Island 02912-9120
Tel 401-863-3100 Fax 401-863-3955
Email: conference_services@brown.edu
www.brown.edu/conferenceservices

NOTE: Student room assignments CANNOT be made until this form has been received.
This form does not require a physician's signature.

STUDENT CONTACT INFORMATION

Please print

Student's Name _____ Gender: Male Female

Parent/Guardian Name(s) _____

Home Phone: _____ Student cell _____

Parent/Guardian Day Phone: _____ Evening phone _____

Emergency Contact: _____ Relationship _____

Emergency Day phone: _____ Evening phone _____

MEDICAL HISTORY & AUTHORIZATION

INSURANCE COVERAGE: You must show proof of health insurance coverage with a US carrier. If proof is not listed, you will be placed on Brown's student health insurance plan for a cost of \$60. This plan has limited coverage. Please contact the Office of Summer & Continuing Studies for more information.

Insurance Carrier _____ Policy Number _____

Carrier Address _____ Carrier Phone _____

Name of policy holder _____

Please attach a copy of both sides of your insurance card.

MEDICAL HISTORY

1. Are you receiving any kind of treatment for medical condition such as asthma, diabetes, a heart condition, high blood pressure, emotional, neurological, convulsions, other, etc.? If so, what is the medical condition?

2. List any medication that you currently take: _____

3. Please list any know allergies to drugs, food, and insects. Do you require an Epi-Pen? YES NO If YES, please explain.

4. Do you have or have you had any history of the following:

Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Cholesterol	<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting or Dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO				

5. Do you have any limiting medical conditions (temporary or permanent)? YES NO If YES, please explain.

6. Do you have any of the following conditions (if YES, please explain):

Recent injury or infectious disease YES NO _____

Chronic or recurring illness YES NO _____

Recent surgery YES NO _____

→ SEE REVERSE SIDE

STUDENT NAME: _____

7. Please describe, list or provide a report or statement for any other concerns, medical or otherwise, you wish to bring to our attention:

EMERGENCY CONTACT INFORMATION

In the event of an emergency, we will call the student's parent/guardian first as listed in the Student Contact Information. If we cannot reach the parent/guardian, we will call the alternate contact as designated in the Student Contact Information. (Please be sure to inform the Office of Summer and Continuing Studies of any changes during the summer program.)

AUTHORIZATION FOR TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

During the summer, it may become necessary for a student of a Brown University summer program to receive medical services. In order to obtain and provide appropriate medical services under these circumstances, parental permission must be obtained in advance for all students under the age of 18. The parent/guardian will be notified as early as possible of an illness or injury, informed of the situation, and consulted about important medical decisions. However, a serious accident or injury may require immediate action and/or treatment without prior notification to the parent or guardian.

Parent/Guardian Authorization

- I acknowledge that I have an obligation to provide the requested medical information to Brown University Summer Programs or designee prior to my son/daughter/ward's participation in the program and to disclose any injuries, or illnesses, she/he may suffer or may have suffered subsequent to signing this form. I agree to assume all risks and hazards resulting from any undisclosed injuries or illnesses. Further, I authorize the Dean or designee, at any time and from time to time during the program, to take such action deemed necessary or desirable for my son/daughter/ward's welfare when she/he is transported to a health care facility for treatment to be rendered to him/her under the general or special supervision of a nurse, dentist, physician, or surgeon licensed to practice in the State of Rhode Island.
 - a. When the nature and severity of the illness or injury requires treatment beyond the capabilities of the Brown University Health Services, in the judgment of Health Services personnel;
 - b. In the event of an accident or emergency requiring immediate medical attention and/or treatment.
- I agree to assign the benefits of personal coverage of medical insurance for my son/daughter/ward to the appropriate providers of his/her medical care. In the event that appropriate medical coverage under my medical insurance plan is unavailable, insufficient, or denied with respect to treatment or services provided by son/daughter/ward, I hereby agree to assume all financial liability and responsibility of all expenses and costs associated with said transportation and/or treatment of his/her illness or injury.
- In consideration of Brown University's allowing my son/daughter/ward to participate in the program and agreeing to intervene on my behalf to provide or make arrangements to provide medical assistance to him/her as needed, I agree to release and indemnify Brown University, including the Corporation, its Trustees, faculty, employees, staff, and other agents from all liability and responsibility for any claims, demands, actions, or other proceedings for any personal injury, accident damage, expenses, or other loss caused, suffered, or incurred by him/her or any other person or entity arising out of his/her participation in the program, unless caused by the willful negligence of Brown University.
- I acknowledge that I have read and understand the above statements and that if I am unable to do so, for whatever reasons, I have had them read to me and am confident that the individual so doing has read and/or translated the statements truthfully and in their entirety.

MEDICAL CARE AUTHORIZATION FOR ALL STUDENTS

- I, the student, hereby specifically authorize the Brown University Health Services and/or any authorized member of its staff, or duly affiliated consultant, to provide care and treatment to the student and for emergency treatment.

***If student is under 18 years of age, parental signature is required.**

Parent/Guardian signature: _____ Date: _____

Student signature: _____ Date: _____

RETURN THIS FORM TO:

Brown University
ATTN: Conference Services
Box 1946
Providence, RI 02912-9120
Fax: 401-863-3955