Banner ID_____ (office use only)

MEDICAL AUTHORIZATION FORM

NOTE: Student may not participate in Continuing Education programs until this form has been received. **This form does not require a physician's signature.**

BROWN

Brown University, Box T
Providence, RI. 02912-3916
Phone 401-863-7900
Fax 401-863-3916
summerapply@brown.edu

STUDENT CONTACT INFORMATION **Please print**

Student is attending: ☐ Pre-College Summer Course(s) ☐ SPARK Science for Middle School Course(s) ☐ Global Program(s) ☐ Sports Camp(s)
(Check all that apply) ☐ Intensive English Program ☐ TheatreBridge and Playwrights Workshop ☐ Leadership Institute ☐ Visiting Undergrad

Student's Last Name _____ First Name _____ Gender ☐ Male ☐ Female

Home Address _____ City/State/Zip/Country _____

Date of Birth (mm/dd/yy) _____ Parent/Guardian Name(s) _____

Parent/Guardian Address (if different from above) _____

Home Phone _____ Student Cell Phone _____

Parent/Guardian Day Phone _____ Parent/Guardian Evening phone _____

Parent/Guardian Cell Phone _____ Emergency Contact Name _____

Emergency Contact Relationship _____ Emergency Contact Cell 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 automatically be enrolled in Brown's student health insurance plan for a fee for the length of your program. This plan has limited coverage.

Insurance Carrier: _____ Policy Number: _____

Carrier Address: _____ Carrier Phone: _____

Name of policy holder: _____

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? **If you will bring any injectable medications to the program or medications that require refrigeration, please complete and submit a Disability and Medical Accommodation Form to Student and Employee Accessibility Services (SEAS) in advance.** _____

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.

   _____

   If you have a food allergy, requiring special meals or other accommodations please complete and submit a Disability and Medical Accommodation Form to Student and Employee Accessibility Services (SEAS) and Catering Allergy Form.

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

Heart Disease	☐ YES	☐ NO	High Blood Cholesterol	☐ YES	☐ NO	Asthma	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Fainting or Dizziness	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Sickle Trait	☐ YES	☐ NO			

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

   _____

   _____

STUDENT NAME: _____

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	_____

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

_____

_____

If you have any disability-related concerns or current injuries, if you have a current IEP or 504 plan, if you have a significant food allergy, or will require any academic accommodations, or if you will require a special housing accommodation due to a physical or mental health concern, please complete and submit a Disability and Medical Accommodation Form to Student and Employee Accessibility Services (SEAS). Students with significant food allergies must also submit a Guest Allergy Form. Please be aware that all accommodation requests will be considered however there may be limits as to what can be provided without sufficient notice. SEAS recommends a minimum of two weeks notice. Please contact SEAS at seas@brown.edu or (401) 863-9588 with any questions.

☐ **I have read the above information regarding the Disability and Medical Accommodations Form and understand that I must complete that form to indicate the existence of a disability and need for accommodation. This medical form does not serve that purpose and is not shared with SEAS.**

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 Continuing Education of any changes during the program.)

AUTHORIZATION FOR TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

During the program, it may become necessary for a student of a Brown University Continuing Education 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 Continuing Education 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 form 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 me and for emergency treatment.

***If student is under 18 years of age, parental signature is required. This form is valid for one year from the date signed below.**

Parent/Guardian signature: _____ Date: _____

Student signature: _____ Date: _____