BROWN
Simmons Center for the Study of Slavery & Justice

MEDICAL AUTHORIZATION AND HEALTH HISTORY FORM

NOTE: You may not participate in programs until this form has been received.

This form is utilized when students require medical care. Information provided on this form will be made available to healthcare providers and Simmons Center Summer Institute staff.

EMERGENCY CONTACT INFORMATION

In the event of an emergency, we will call the student's parent/guardian first as listed in the Participant Contact Information. If we cannot reach the parent/guardian, we will call the emergency contact as designated in the Participant Contact Information. Please be sure to inform our office of any changes during the program. **The emergency contact listed below must be accessible when the program is in session. For programs located on the Brown University campus, if the parent/guardian will not be in the United States when the participant is taking part in the program, a contact within the United States is strongly**

PARTICIPANT CONTACT INFORMATION

Participant is attending an academic program through Brown University 's Simmons Center for the Study of Slavery & Justice

Last Name: ____________________ First Name: ____________________ Date of Birth: ____________

Gender: ☐Male ☐Female ☐Self-defined Participant Cell Phone: ____________

Home Address: ____

City/State: ____________________ Zip Code: ________ Country: ____________

Parent/Guardian Name(s): ____________________ Parent/Guardian Phone: ____________

Emergency Contact Name: ____________________

Emergency Contact Relationship: ____________________ Emergency Contact Phone: ____________

INSURANCE COVERAGE

Do you have insurance that is valid and offers coverage in the United States?

☐Yes ☐No

If yes, please indicate proof of health insurance coverage with a U.S. carrier below.

If you are an international student, or if you are a U.S. student who does not provide proof of health insurance with a U.S. carrier, you will automatically be enrolled in Brown's Limited Accident and Sickness, Short-term Insurance Plan for a fee of $80 for the length of your program. This plan has limited coverage in the event of an accident or emergency illness while on campus or during program-sponsored activities and is subject to a deductible.

Insurance Carrier: ____________________ Policy Number: ____________________

Carrier Address: ____________________ Carrier Phone: ____________________

Name of Policy Holder: ____

AUTHORIZATION FOR TREATMENT FOR PATIENTS UNDER 18 YEARS OF AGE

During the program, it may become necessary for a participant of the Simmons Center Summer Institute to receive medical services on or off campus. In order to provide appropriate medical services under these circumstances, parental/guardian permission must be obtained in advance for all participants 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/guardian.

PARENT/GUARDIAN AUTHORIZATION

I acknowledge that I have an obligation to provide the requested medical information to Simmons Center Summer Institute or designee on the Medical and Immunization History Form prior to my child's participation in the program and to disclose any injuries, or illnesses they 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 during the program, to take such action deemed necessary or desirable for my child's welfare when they are transported to a health care facility for treatment to be rendered to them under the general or special supervision of a nurse, dentist, physician, or surgeon licensed to practice.

a. When the nature and severity of the illness or injury requires treatment beyond the capabilities of Brown University Health Services, in the judgment of Health Services personnel; and/or

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 child to the appropriate providers of their 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 child, I hereby agree to assume all financial liability and responsibility of all expenses and costs associated with said transportation and/or treatment of their illness or injury.

In consideration of Brown University's allowing my child to participate in the program and agreeing to intervene on my behalf to provide or make arrangements to provide medical assistance to them 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.

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

This form is valid for one year from the date signed below.

Parent/Guardian Signature: ____________________________________ Date: ________________

Participant Signature: ____ Date: ________________

To be completed by a Parent/Guardian:

Does the participant have a history of any of the following conditions:

☐No ☐Yes Chronic/recurring illness
☐No ☐Yes Diabetes
☐No ☐Yes Eating Disorder
☐No ☐Yes Heart Condition
☐No ☐Yes Neurological Disorder
☐No ☐Yes Recent Surgery
☐No ☐Yes Seizure Disorder
☐No ☐Yes Asthma
☐No ☐Yes Fainting/dizziness
☐No ☐Yes Sickle Trait
☐No ☐Yes Other: ______________________

If yes to any of the above questions, please explain: ______________________

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Does the participant have any allergies to food or beverages? ☐ No ☐ Yes

If yes, please list: ______________________

Does the participant have any allergies to things other than food or beverage? ☐ No ☐ Yes

If yes, please list: ______________________

Does the participant carry an Epi-pen? ☐ No ☐ Yes

Is the participant currently taking any prescription or injectable medications? ☐No ☐Yes

Is the participant currently taking any over-the-counter medications, vitamins or supplements? ☐No ☐Yes

Does the participant have any predisposing physical or mental health conditions which under stress of adjusting to living in new surroundings may require support and/or treatment? ☐No ☐Yes

If yes, please explain: ______________________

____

Other medical information relevant to routine support and/or treatment?

If yes, please explain: ______________________

____

Other medical information relevant to routine care and emergencies: ______________________

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May the participant engage in all program activities, including sports? ☐No ☐Yes

If no, please list restrictions both temporary and permenant: ______________________

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Does the participant require a reasonable accommodation due to a disability , including but not limited to medical conditions, temporary injuries and significant food allergies? ☐ No ☐ Yes

If yes, please select the nature of your reasonable accomodation request(s):*

☐ Academic/Learning (most Pre-College courses do not have exams or graded assignments)

☐ Dietary (i.e significant food allergy to gluten, wheat, milk, soy, fish, shellfish, eggs or nuts)

☐ Medical

☐ Physical, mobility, hearing, or visual impairment

☐ Housing

**Please note that you may be asked to provide documentation of the existence of a disability and evidence of the need for a reasonable accommodation (for example a letter from your doctor or therapist).*

Please describe your disability in more detail and list any reasonable accomodations you would like to request:

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I understand that information about my disability will be released to the Simmons Center for the Study of Slavery & Justice and may be shared with Brown University officials and employees for the purpose of coordinating services and accommodations. I also understand that the Division may require documentation that establishes eligibility prior to receiving accommodations. This release will serve for the duration of my enrollment at the Simmons Center unless otherwise requested.

____________	____________	____________
Student Initials	*Parent/Guardian initials (if under 18)*	*Date*

List all current providers (Physician, Allergist, Psychologist, etc.)

PROVIDER NAME	SPECIALTY	PHONE NUMBER

If there are any medical concerns that should be brought to our attention, please contact Brown University Health Services at *401-863-3953* or email *nursing@health.brown.edu.*

I certify that all of the information provided in this form is accurate.

Parent/Guardian signature ______________________________ Date __________

Participant signature ______________________________ Date __________