

Brown Summer Programs Medical Authorization Form

This form does **not** require a physician's signature.

Full legal name of student _____ Date _____
FAMILY, FIRST, MIDDLE

Parent's or guardian's name (if student is under 18) _____ Date _____
FAMILY, FIRST, MIDDLE

Date of birth _____ Age _____ Sex _____

Home address _____

Country _____ Phone _____

Program of study _____

Important: Individuals with disabilities, time is of the essence. If you have reason to believe you qualify, according to Federal Statute, for special accommodations for disability, please so indicate by checking the block below. Relevant portions for Section 504 of the Federal Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 require that you identify yourself so that reasonable accommodations can be arranged. If you think you qualify, you must return this form to us no later than 45 days prior to your arrival on campus.

____ Yes, I have reason to believe I qualify for special accommodations for disability ____ Not applicable

INSURANCE COVERAGE: You must show proof of health insurance coverage with a U.S. carrier. If proof is not listed, you will be placed on Brown's student health insurance plan for a cost of \$50. This plan has limited coverage, please contact the Office of Summer Studies for information.

Insurance carrier _____ Policy number _____

Carrier address _____ Carrier phone _____

Name of policy holder _____
PLEASE ATTACH A COPY OF YOUR INSURANCE CARD. COPY BOTH SIDES OF THE CARD.

MEDICAL HISTORY

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

List any medications that you currently take: _____

Please list any known allergies to drugs, food, and insects. Do you require an Epi-Pen? _____

Are there any other concerns, medical or otherwise, you wish to bring to our attention so we can better meet your needs during your stay at Brown? If so, please attach a separate statement.

EMERGENCY CONTACT INFORMATION In the event of an emergency, we will call the student's parent/guardian first. If we cannot reach the parent/guardian, we will call the alternate contact designated below. (Please be sure to inform the Office of Summer Studies if any of this information changes during the summer program.)

Parent/guardian _____ Relationship _____

Summer address _____

Summer phone Business/day (____) _____ Evenings (____) _____ Cell (____) _____

Alternate emergency contact _____ Relationship _____

Alternate phone Business/day (____) _____ Evenings (____) _____ Cell (____) _____

► **SEE OTHER SIDE**

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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 undersigned parent or 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.

1. I, _____, of _____

PARENT (NAME OF PARENT/GUARDIAN)

ADDRESS

am the parent/guardian having legal custody of _____

STUDENT NAME

I acknowledge that I have an obligation to provide the requested medical information to the Dean of Summer Studies or designee prior to my son/daughter/ward's participation in the program and to disclose any injuries, or illnesses, s/he may suffer or may have suffered subsequent to by returning 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 s/he is sick or disabled, including without limitation, to transport or make arrangements to transport him/her to a hospital or other 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.
2. 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 the treatment or services provided by son/daughter/ward, I hereby agree to assume all financial liability and responsibility for all expenses and costs associated with said transportation and/or treatment of her/his illness or injury.
 3. 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.
 4. I acknowledge that I have read and understand the above statements and that if I am unable to do so, for whatever reason, 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 undersigned, 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."

Student _____ Parent _____ Date _____

Witness _____

Signatures: If under 18 years of age, parental signature is also required.