

Summer Institute Student Health Form

Please fill out the entirety of this form to the best of your ability. All collected information is confidential and will only be used to care for the student in the case of a medical event or emergency.

STUDENT INFORMATION

Select your program below.

Art, Media & Design	Creative Writing	Dance
Filmmaking	Music	Music Composition and Songwriting
Music Industry	Screenwriting	Theater

UArts Student ID Number

<i>Last Name</i>	<i>Legal First Name</i>	<i>Chosen First Name (If Applicable)</i>
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<i>Date of Birth</i>	<i>Legal Sex</i>	<i>Gender Identity</i>
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<i>Home Address</i>	<i>City</i>
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<i>State</i>	<i>Zip Code</i>	<i>Country</i>
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<i>Home Phone</i>	<i>Student Cell Phone</i>	<i>Student Email Address</i>
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<i>Emergency Medical Contact Name</i>	<i>Relation to Student</i>	<i>Emergency Contact Cell Phone</i>
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Note: The emergency medical contact should be a person that would be easily available to aid the student and staff in the event of a medical emergency.

Are you living on campus?
Yes No

HEALTH INSURANCE

It is highly recommended that students have a photo or copy of their insurance card on them at all times.

<i>Name of Insurance Company</i>	<i>Type of Plan (PPO, HMO, etc.)</i>
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<i>Insurance ID Number</i>	<i>Group Number</i>
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<i>Insurance Company Phone Number</i>	<i>Subscriber's Full Name</i>
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<i>Subscriber's Date of Birth</i>	<i>Student's Relationship to Subscriber</i>
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PHYSICIAN INFORMATION

Physician/Practitioner Name

Physician Phone Number

Office Address

MEDICAL HISTORY

List any ongoing medical conditions that our office should be aware of.
(Ex. Seizure Disorder, Diabetes, etc.)

Has the student been treated for the following?

Anxiety or Panic Disorder

Depression

Eating Disorder

Substance Abuse

Additional Notes: _____

Additional Information

Is the student currently taking any medication or supplements?*

No

Yes

If yes, please list:

Has the student had surgery or a serious injury?

No

Yes

If yes, explain: _____

Has the student traveled outside of the U.S. in the past year?

No

Yes

If yes, explain: _____

***Note:** We are unable to fill, write, administer, or handle student medication. Please plan accordingly.

ALLERGY INFORMATION

Do you have any allergies? Yes No Do you carry an Epi Pen? Yes No

List all allergies (including food, medicine, etc.).

Additional Notes

REQUIRED IMMUNIZATIONS

If available, attach your full immunization record to this form.
 Visit uarts.edu/si-policies to learn more about our vaccination policy.

COVID-19 (Novel Coronavirus) *The full dose must be administered two weeks prior to arrival on campus to show immunity.*

Dose 1

___/___/___
MM/DD/YYYY

Manufacturer: _____

Dose 2*

___/___/___
MM/DD/YYYY

Manufacturer: _____

**If applicable*

Dose 3*

___/___/___
MM/DD/YYYY

Manufacturer: _____

**If applicable*

Measles, Mumps, Rubella *Two doses of vaccine to show immunity*

MMR Dose 1

___/___/___
MM/DD/YYYY

MMR Dose 2

___/___/___
MM/DD/YYYY

OR

Measles Dose 1

___/___/___
MM/DD/YYYY

Measles Dose 2

___/___/___
MM/DD/YYYY

Mumps Dose 1

___/___/___
MM/DD/YYYY

Mumps Dose 2

___/___/___
MM/DD/YYYY

Rubella Dose 1

___/___/___
MM/DD/YYYY

Rubella Dose 2

___/___/___
MM/DD/YYYY

Meningococcal* **(serotype A, C, Y and W-135) Two doses of vaccine to show immunity*

Meningococcal Dose 1

___/___/___
MM/DD/YYYY

Meningococcal Dose 2

___/___/___
MM/DD/YYYY

Specify which vaccine type or serotypes:

Note: Students must have received a dose on or after the age of 16 to be considered fully immunized.

MEDICAL RELEASE

If a student requires unexpected medical, dental, health, psychological or hospital services while they are participating in summer programs at UArts, the consent of a parent/guardian is required. Care may be rendered only with such consent, except in a true emergency. Although the university will make every effort to contact a parent/guardian in the event of an emergency, attempting to reach them for permission to treat or obtain insurance information can delay treatment. This document enables UArts to arrange for health care services for your child and to provide insurance information to the provider. This document shall be presented to appropriate medical professionals or their representatives at such time as care may be required. All information within this document is confidential and will only be referenced and used to enact care for the student.

AGREEMENT

As the responsible parent/guardian, I understand that the university requires medical information about the student applicant, and I authorize the student's physician to provide the same. I also understand that the university will provide reasonable accommodation for students with disabilities who disclose and provide documentation of the disability. I also authorize the nursing staff of University of the Arts to administer the following over the counter medication to my child as needed: acetaminophen (Tylenol), ibuprofen (Advil, Motrin), cough syrup, throat lozenges, hydrocortisone cream 1%, and antibiotic ointment (Neosporin).

As the parent/guardian of the aforementioned student, I hereby consent to the following.

- I authorize the release of foregoing information to any appropriate employees of UArts to help ensure the health and/or safety of my child.
- In the event of a medical emergency, I authorize my child to be taken to the nearest medical facilities for care.
- I hereby appoint individuals on staff at UArts to act in my behalf in authorizing medical, dental, psychological, surgical care and/or hospitalization of the above-named student in case of an emergency.
- I authorize UArts to give the medical facility access to my child's medical and insurance records.
- I authorize UArts to contact my child's physician via the information provided on this Health Form.
- If my child is currently self-medicating, according to the information on this Health Form, I hereby give permission for them to continue to self-medicate throughout their stay at UArts.
- I will inform UArts Pre-College Programs of any changes to the student's medical condition as soon as I become aware of them.
- I acknowledge that failure to disclose all information honestly and in a timely fashion may be ground for dismissal from the UArts Pre-College Summer Institute.

HEALTH FORM CONFIRMATION

THIS FORM HAS BEEN COMPLETED TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT SIGNING MY NAME BELOW CONFIRMS THAT I ACKNOWLEDGE AND AGREE TO THIS FORM.

Parent/Guardian Name (Printed): _____ Date: __/__/____

Parent/Guardian Signature: _____

Student Name (Printed): _____ Date: __/__/____

Student Signature: _____

SUBMITTING THE HEALTH FORM

Retain a copy of the completed health form for your records.

The Summer Institute Health Form is comprised of five pages. If available, submit your immunization/vaccination records along with the Health Form.

All pages must be completed and submitted by June 1, 2023.

The Health Form will only be accepted via the following method.

Students must scan a **single PDF** of the health forms and email them to **precollege@uarts.edu**.

The subject line must read "Health Form [Last Name, First Initial]."

QUESTIONS? CONCERNS? CONTACT US

We are here to make sure your student is happy and healthy.

PRE-COLLEGE INQUIRIES

Phone: (215) 717-6430

Email: precollege@uarts.edu

HEALTH SERVICES INQUIRIES

Website: uarts.edu/healthservices

Phone: (215) 717-6652

Email: healthservices@uarts.edu

Open Monday–Friday, 9 a.m.–5 p.m.