

# 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

Last Name

Legal First Name

Chosen First Name (If Applicable)

Date of Birth

Legal Sex

Gender Identity

Home Address

City

State

Zip Code

Country

Home Phone

Student Cell Phone

Student Email Address

Emergency Medical Contact Name

Relation to Student

Emergency Contact Cell Phone

**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.

Name of Insurance Company

Type of Plan (PPO, HMO, etc.)

Insurance ID Number

Group Number

Insurance Company Phone Number

Subscriber's Full Name

Subscriber's Date of Birth

Student's Relationship to Subscriber

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:

\_\_\_\_\_

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

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: \_\_\_\_\_

## 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.

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

MMR Dose 1

\_\_\_/\_\_\_/\_\_\_  
MM/DD/YYYY

OR

Measles Dose 1

\_\_\_/\_\_\_/\_\_\_  
MM/DD/YYYY

Mumps Dose 1

\_\_\_/\_\_\_/\_\_\_  
MM/DD/YYYY

Rubella Dose 1

\_\_\_/\_\_\_/\_\_\_  
MM/DD/YYYY

MMR Dose 2

\_\_\_/\_\_\_/\_\_\_  
MM/DD/YYYY

Measles Dose 2

\_\_\_/\_\_\_/\_\_\_  
MM/DD/YYYY

Mumps Dose 2

\_\_\_/\_\_\_/\_\_\_  
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 at 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), 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: \_\_\_\_\_

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## 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.** *Though no longer required, please include COVID-19 vaccination records.*

All pages must be completed and submitted by **June 1, 2024**.

Students must send a **single PDF** of the health form  
via email to **precollege@uarts.edu**.

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

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## 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.