University of New Haven

SUMMER YOUTH ACADEMY HEALTH RECORD

You must provide a copy of your private insurance company card (front and back), including company name, company phone number, and your identification number. Physical Exams Are Valid For 3 Years From Date of Last Examination.

Name Last First Middle Initial **Birth Date** / / **Age**

Sex Assigned at Birth **Gender Identity** **Pronouns** **Chosen Name**

Home Phone **Cell Phone**

Parent/Guardian Full Name **Guardian/Spouse Full Name**

Address Street City State Zip

IN CASE OF EMERGENCY NOTIFY *(Please Print)*

Full Name **Relationship**

Address

Work Place **Home Phone** **Cell Phone**

TO BE COMPLETED BY THE HEALTHCARE PROVIDER

May participate in all camp activities: ❑ YES ❑ NO

May participate except for: _____

Does the individual have any known medical or emotional illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp? ❑ YES ❑ NO

If yes, please explain: _____

Are there any prescription or over the counter medication(s) this individual needs to take while at camp? ❑ YES ❑ NO
If yes, then complete this written authorization and parent permission form for medication administration. This form is only to be used by those who want current medication to be administered by an authorized person.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? ❑ YES ❑ NO
NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If yes, please explain: _____

If camper is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health pursuant to section 19a-7f of the Connecticut General Statutes?

❑ YES ❑ NO

Additional Comments: _____

HEALTH CARE PROVIDER (Please print or use stamp)

Print Clinician's Name Last First **Phone Number** / / **Fax Number**

Address Street City State Zip

Clinician's Signature and Title **Assessment Date**