2020 Young Scholars Senior Summit
Health History and Consent for Treatment

Instructions: **This form (pages 1-3) is to be completed by a parent/guardian.** The form may be typed on, or handwritten. Then, you may print the filled form to sign. A completed form includes all information mentioned below, including **hand** signatures from both the parent/guardian and participant.

For questions regarding this form, contact **Lisa Muller at 860-486-4676 or lisa.muller@uconn.edu**

PARTICPANT LAST NAME:	PARTICIPANT FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH: ___/___/_____
HOME PHONE:	CELL PHONE:		SEX: Male ___ Female __ Other: _____
HOME ADDRESS:	CITY:	STATE:	ZIP CODE:
PARENT/GUARDIAN NAME:	WORK PHONE:	CELL PHONE:	
ADDT'L PARENT/GUARDIAN NAME:	WORK PHONE:	CELL PHONE:	
IF UNAVAILABLE IN AN EMERGENCY, PLEASE CONTACT:			
NAME & RELATIONSHIP TO PARTICIPANT:	WORK PHONE:	CELL PHONE:	
PERSONAL PHYSICIAN/HEALTHCARE PROVIDER			
PHYSICIAN NAME:	PHONE NUMBER:		
HEALTH INSURANCE INFORMATION			
INSURANCE COMPANY NAME:	ADDRESS:		
INSURANCE ID NUMBER:	GROUP NUMBER:		
GUARANTOR FULL NAME (primary policyholder i.e., mother, father, etc.):	GUARANTOR ADDRESS (street, town, state, & zip):	GUARANTOR DATE OF BIRTH: ___/___/_____	
Does your health insurance cover prescription medications? (please mark):		No	Yes
Proof of Insurance Coverage: All participants should be enrolled in health care insurance while attending the Program in the event of receiving medical services. For this reason, participants are required to carry a photo ID and health insurance card**.**			

HAS YOUR CHILD/WARD EVER BEEN DIAGNOSED WITH A PHYSICAL OR MENTAL HEALTH CONDITION? A participant's mental/physical health, as long as they are independently functioning, will not prevent them from attending the Young Scholars Senior Summit Program. The program staff need to know of any health issues/concerns **so that we can accommodate your child/ward accordingly. If yes, please check the appropriate box per medical condition or write-in conditions as needed.**

NO	YES		(CHECK YES OR NO)
	BUT NOT CURRENT	CURRENT DIAGNOSIS	
			ADHD (ATTENTION-DEFICIT HYPERACTIVITY DISORDER)
			ASTHMA
			ANXIETY DISORDER
			SOCIAL ANXIETY DISORDER
			DEPRESSION (Please specify current severity):
			BIPOLAR DISORDER
			PANIC DISORDER
			CONVULSIONS/SEIZURES
			DIABETES (TYPE I OR TYPE II)
			PHYSICAL DISABILITY (EXPLAIN):
			OTHER EMOTIONAL/MENTAL HEALTH CONDITION (EXPLAIN):
			PREVIOUS HOSPITALIZATION/SURGERY (EXPLAIN):
			PREVIOUS INJURY (EXPLAIN):
NO	**YES**		**MY CHILD/WARD HAS/IS:**
			ALLERGIES TO MEDICATION (LIST):
			FOOD ALLERGIES (LIST):
			DIETARY RESTRICTIONS (LIST):
			OTHER ALLERGIES (LIST):
			A HISTORY OF SELF-HARM OR ANY OTHER UNSAFE BEHAVIORS TOWARDS SELF OR OTHERS (Explain):
			UNDER A PHYSICIAN'S CARE FOR THE FOLLOWING CONDITION:
			ANOTHER MEDICAL CONDITION STAFF SHOULD KNOW OF:
NO	**YES**		**MY CHILD/WARD IS CURENTLY TAKING MEDICATIONS:***
			MEDICATION 1: DOSAGE: REASON:
			MEDICATION 2: DOSAGE: REASON:
			MEDICATION 3: DOSAGE: REASON:
			MEDICATION 4: DOSAGE: REASON:
			MEDICATION 5: DOSAGE: REASON:

*As stated in our Program policy, an onsite nurse will not be present to administer medication to participants. It is the participant's responsibility to secure and self-administer any necessary prescribed medications. The Program will not provide any prescribed medication.

CONSENT FOR OVER-THE-COUNTER MEDICATION

I, the undersigned, hereby give my permission for program staff to provide upon request the following over the counter medications during the program, if needed.

NO	YES	(CHECK YES OR NO)
		PAIN RELIEF (E.G., ACETAMINOPHEN, IBUPROFEN)
		ALLERGY RELIEF (E.G., CALAMINE LOTION, CORTZONE CREAM, BENEADRYL)
		ANTACIDS (E.G., TUMS, PEPTO-BISMAL)

CONSENT FOR TREATMENT

I hereby grant permission for UConn Health Urgent Care or other appropriately deemed medical services and Program staff to provide my child/ward with appropriate medical and mental health services or access to these services. These services may include providing medications for treatment of illnesses/injuries, or to arranging for any emergency medical care. I understand UConn Health Urgent Care and other medical services may disclose information from my child/ward's medical records (including treatment, payment, healthcare operations, etc.) to appropriate University personnel, parents/guardians, and/or listed emergency contacts.

Parents/guardians will assume financial responsibility for all expenses of such care. This authorization is given in advance of any such medical treatment and is given to provide authority and power on the part of the University of Connecticut in the exercise of its best judgment upon the advice of any such medical or emergency personnel.

In submitting this form, I, the undersigned, hereby certify that, to the best of my knowledge, the medical information furnished herein is true and complete.

I, the undersigned, believe my child/ward is capable of refraining from unsafe and/or harmful behaviors toward self and others.

I, the undersigned, acknowledge that I have read and understand this consent, and that any questions I have prior to signing this can be answered by calling Lisa Muller at 860-486-4676.

If I have any questions regarding medical services offered at UConn Health Urgent Care, I understand that any questions can be directed to UConn Health Urgent Care at (860) 487-9300.

Parent/Guardian Name (Print):	Relationship:	Parent/Guardian Cell Phone Number:
Participant signature: Date: ___/___/_____	Parent/Guardian Signature: ___/___/_____	Date:

PLEASE KEEP A COPY THIS HEALTH HISTORY FORM FOR YOUR RECORDS

Print, sign, scan, and upload this document to your YSSS registration.