

RESIDENTIAL PACKET

Summer Health Form Info required by Vassar College

Last Name _____ First _____ Initial _____ Birthdate _____ Sex _____ Age _____

Parents/Guardian _____

Home Phone _____ Work Phone _____ Cell Phone _____

Home Address _____ City _____ State _____ Zip _____

If parents/guardians not available in emergency, notify:

1. Name (local if possible) _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Name (local if possible) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Information:

Provider _____ ID/Policy # _____

Authorization to release child — Under no circumstances will my child/children be released to individuals other than those listed above without my written authorization.

Health History (check and give approximate dates)

- Ear Infections _____
- Rheumatic Fever _____
- Convulsions _____
- Diabetes _____
- Behavior _____

Allergies

- Hay Fever _____
- Poison Ivy, etc. _____
- Insect Sting _____
- Penicillin _____
- Other Drugs _____

Disease

- Chicken Pox _____
- Measles _____
- German Measles _____
- Mumps _____
- Asthma _____

Operations or Serious Injuries (dates) _____

Chronic or Recurring Illness _____

Other Diseases or Details of Above _____

Any specific activities to be restricted? _____

Important: Please notify the campus if this student is exposed to any communicable diseases during the three weeks prior to camp attendance.

I give my permission for The Art Institute/Mill Street Loft to use photographs and/or video tapes of my child taken during program activities for educational and/or promotional materials. No names will be used with photos.

Signature _____ Date: _____

This health form is correct as far as I know, and the person herein described has permission to engage in all prescribed institute activities, except as noted by me and the examining physician. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected or the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child.

Signature _____ Date: _____

MUST BE ATTACHED TO THIS FORM:

- * An updated and complete immunization record
- * A copy (front & back) of your medical insurance card

