ENVIRONMENTAL STUDIES SUMMER YOUTH INSTITUTE

HEALTH FORM

The Colleges require completion of this form for participation in the Institute. This record of your medical history and a recent physical examination will be used to render effective medical care if necessary. The immunization record must be complete. Part I should be completed by the student and parents. Part II must be completed by your physician.

PART I: Personal Medical History (to be filled out by student and parents)

Full Name: _____

Birthdate: _____Social Security No. _____

Home address: _____

Person(s) to be notified in an emergency (please list in order of preference):

Name _____ Relation _____

Address _____ Phone _____

Name _____Relation _____

Address _____ Phone _____

Have you ever had or do you now have any of the following conditions? (If yes, give details below)

	YES	NO		YES	NO		YES	NO
Asthma			**Depression**			**Measles**		
Swimmer's Ear			**Middle Ear Infections**			**Mumps**		
Fainting			**Surgery or Serious Injuries**			**German Measles**		
Convulsions			**Eye Problems**			**Bee-sting Allergy**		
Seizures			**Kidney Problems**			**Drug Allergy**		
Poliomyelitis			**Heart Problems**			**Food Allergy**		
Tuberculosis			**Sleep Walking**			**Other Allergy**		
Hepatitis			**Rheumatic Fever**			**Severe Reaction to poison ivy, poison Oak or sumac**		
Serious Stomach Problems			**Diabetes**					
Constipation			**Chicken Pox**					
Eating Disorder			**Whooping Cough**					

Explanation of conditions marked "yes" above: _____

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HOBART AND WILLIAM SMITH COLLEGES • GENEVA, NEW YORK

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Health Insurance

Name of Insurer _____
Company address _____
Name of Insured_____ Policy number _____

Authorization for Treatment

If my child needs medical treatment while at the Institute, I hereby give permission to the physician selected by Institute staff to commence such medical treatment as the physician deems necessary, including, without limitation, hospitalization, securing proper medical treatment for, and ordering injection, anesthesia or surgery for my child. I accept responsibility for all costs related to such treatment whether or not covered by my health insurance policy. I understand that every effort will be made to contact me when the need for such medical treatment arises and that such efforts will continue to be made until they are successful.

☐ I request that my child's medication be held on to by an ESSYI staff member and dispensed as needed.

Signature of Parent/Guardian _____ Date _____

PART II: Medical Examination (To be completed by licensed physician within three months prior to student's arrival at the Institute, based on an examination conducted no more than 12 months prior to said date.)

Patient's Name _____Examination Date _____
Height _____ Weight _____Blood Pressure _____Pulse Rate _____
Vision OD _____Vision OS_____ Color vision _____

Clinical Evaluation

Check each item in the appropriate column; enter NE if not evaluated. Please provide a detailed explanation of all abnormalities. Please check of "**N**" for "Normal" and "**A"** for "**Abnormal**".

	N	A		N	A		N	A
Head, face, scalp			**Neck: Thyroid**			**Endocrine System**		
Nose			**Chest and lungs**			**G-U System**		
Mouth and Throat			**Breasts**			**Upper Extremities**		
Teeth			**Heart**			**Lower Extremities**		
Ears			**Vascular System**			**Feet**		
Hearing			**Abdomen and viscera**			**Other musculoskeletal, spine, scoliosis**		
Eyes: General			**Hernia**			**Skin lymphatics**		
Ophthalmoscopic			**Anus and rectum**			**Neurological**		

Notes: Explain abnormalities in detail.

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Recommendations

If treatment for a chronic condition will be required while the student attends the Institute, please explain..

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Are there any illnesses, injuries or abnormalities in the student's medical history that would preclude participation in physical exercise? If yes, please explain.

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Immunization Record

Please indicate month and year.

	Date		**Date**
D.P.T. Series Booster		**DT or Tetanus Booster**	
Polio Series Booster		**Measles Booster**	
Rubella		**Mumps**	

Medications

• ***All*** prescription medications ***must*** by in their original containers, specifying times, dosages, and indications.

• ***All*** students using an EPI-pen ***must*** inform an ESSYI staff member each time that it is self-administered.

Medication	**Route (include formulation)**	**Dosage**	**Schedule and Indications**	**Comments**

Examining physician's name (print or type) _____

Examining physician's signature _____

Address _____

Phone Date _____

Parent signature_____

Date _____