STUDENT NAME _____

This form is due by May 15, 2022 and may be submitted separately from the rest of the packet. Please attach a copy of the student's insurance card and a copy of the insurance holder's ID card along with this Health Form.

Please note this form is separate from any official University of Denver required Covid-19 release forms or paperwork.

This form should be completed and signed by the student's parent/legal guardian if the student is under 18 and physician. This information is necessary in the event that the student needs medical attention while the LSA is in session.

STUDENT INFORMATION

Please complete using information as shown on insurance information and identification.

Student's Name _____
Permanent Address _____ Date of Birth _____ Sex___
City/State/Zip _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:	Backup contact:
Name _____	Name _____
Relation _____	Relation _____
Daytime Phone _____	Daytime Phone _____
Evening Phone _____	Evening Phone _____

INSURANCE POLICY INFORMATION

The above-named student is covered by health insurance: Yes No
If yes, provide the following information

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____
Address _____ Relation _____
City/State/Zip _____ Occupation _____
P.H.'s Employer _____
Employer's Address _____
Insurance Company _____
Insurance Company's Address _____
Policy # _____ Plan # _____

☐ **Attach a photocopy of policyholder's ID card**
☐ **Attach a copy of student's insurance card**

STUDENT NAME _____

HEALTH PERMISSION

I HEREBY GIVE PERMISSION TO THE LAMONT SUMMER ACADEMY (LSA), THE UNIVERSITY OF DENVER (DU), AND ITS REPRESENTATIVES TO PROVIDE ROUTINE HEALTHCARE AND SEEK EMERGENCY TREATMENT, INCLUDING BUT NOT LIMITED TO THE ORDERING OF X-RAYS OR ROUTINE TESTS. I AGREE TO THE RELEASE OF ANY RECORDS NECESSARY FOR INSURANCE PURPOSES. I GIVE PERMISSION TO THE LSA AND DU TO ARRANGE NECESSARY RELATED TRANSPORTATION FOR ME/MY CHILD. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN, OTHER LICENSED HEALTH CARE PROVIDER, AND/OR HOSPITAL SELECTED BY THE LSA AND/OR DU TO SECURE AND ADMINISTER TREATMENT INCLUDING HOSPITALIZATIONS, INJECTIONS, ANESTHESIA OR SURGERY FOR THE PERSON NAMED ABOVE. THIS COMPLETED FORM MAY BE PHOTOCOPIED. THE LSA, DU, AND ITS REPRESENTATIVES HAVE PERMISSION TO OBTAIN COPIES OF MY/MY CHILD'S TREATMENT AND HEALTH RECORD FROM ANY PROVIDER WHO TREATS ME/MY CHILD. I UNDERSTAND THAT INFORMATION ABOUT ME/MY CHILD'S HEALTH WILL BE SHARED ON A "NEED TO KNOW" BASIS WITH LSA STAFF AND WILL BE KEPT CONFIDENTIAL. THIS HEALTH FORM IS COMPLETE TO THE BEST OF MY KNOWLEDGE AND CONTAINS NO MISREPRESENTATIONS OR OMISSIONS THAT MIGHT OR WOULD AFFECT MY/MY CHILD'S EXPERIENCE OR WELL-BEING.

Parent/Guardian Signature (if under 18) Date

Student Signature (if 18 or older) Date

STUDENT NAME _____

DIRECTIONS: **(To be completed by a physician)** This form must be completed before a student can participate in Lamont Summer Academy (LSA) activities. Attach any specific recommendations from your physician.

1. Is there any medical condition we need to be aware of that might impact the participant's participation in any LSA activities? If so, please describe. If the student has asthma and requires an asthma care plan, please complete the Colorado Asthma Care Plan and Medication Order for School and Child Care Settings.

2. Does the participant have any food allergies or dietary restrictions? If so, please describe. If the student has an allergy requiring epinephrine, please complete the Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders.

3. Does the student have any disability, medical condition, or mental health condition for which they may seek a reasonable accommodations? If so, please describe.

4. Is the student current on all vaccinations recommended by the CDC? If not, please identify vaccinations that have not been administered.

5. The following recreational activities are those in which the student may participate during the LSA. Do you recommend that the student be allowed to participate in each activity?

Swimming	☐ Yes	☐ No
Tennis	☐ Yes	☐ No
Climbing Wall	☐ Yes	☐ No
Ice-Skating	☐ Yes	☐ No

PHYSICIAN'S INFORMATION *(to be completed by physician)* Please **PRINT** the following:

Physician's Name: _____

Address: _____

City/State/Zip:_____

Telephone:_____

I have examined the above named participant and found him/her/them to be able to participate in all activities of the Lamont Summer Academy at the University of Denver.

_____	_____	_____
Physician's Signature	Print Name	Date

STUDENT NAME _____

GUIDELINES FOR MEDICATIONS AND AUTHORIZATION FOR ADMINISTRATION OF MEDICATION:

All medications will be kept and self-administered by the student. We ask that you list all medications below, including Epi-pens and inhalers, in the instance that we need to provide this information to a medical professional during an emergency. Please list all **prescription and non-prescription/over-the-counter drugs** below, including all dosing information. Please attach an additional sheet if necessary.

Medication	Dosage	Frequency	Indication

Has the student had a reaction to any of these medications? ☐ Yes ☐ No If Yes, which one?
Please describe reaction:

_____ _____
Signature of Health Care Provider with Prescriptive Authority License Number

_____ _____ _____
Printed Name of Health Care Provider Date Phone

Parent/guardian daytime phone contacts Work _____ Cell _____
Parent/guardian nighttime phone contacts Home _____ Other _____

AUTHORIZATION FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION:
I understand I must provide all medications listed above. Prescription medications must come in an original pharmacy labeled container with student's name, name of medicine, time medicine is to be given, dosage, date and licensed healthcare provider's name. Over the counter medications must be labeled with student's name and packaged in original container. Dosage must match the signed licensed healthcare provider's authorization. I have discussed the risks related to the use of the medications and understand that I (and my child) acknowledge, accept and assume those risks associated with this use of medication. I give permission for my/my child's health care provider to share information about the administration of this medication with personnel acting on behalf of Lamont Summer Academy. I have read and understand the conditions set forth above.

SIGNATURE OF STUDENT_____Date_____
(For students 18 years old and older)

SIGNATURE OF PARENT/GUARDIAN:_____Date_____
(Parent/guardian signature required for students under 18 years of age)