2017 Summer Program
Health Questionnaire

Students: Welcome to your summer program at Barnard College, Columbia University. Before you begin your program on campus, it is necessary that you provide Columbia Health with **(1)** proof of immunity to MMR **(2)** accurate and complete health-related information; **(3)** if you are under 18, written authorization by your parent or guardian for provision of medical treatment and **(4)** documentation of health insurance coverage. This information will be kept in strictest confidence by the program and will be shared only when necessary. A copy of this form will remain on file at Columbia Health, so that we will be prepared to address any medical conditions which may arise. **All sections of this form must be completed.**

Name of your summer program: Barnard Pre-College Programs

Your name:_____ Date of Birth_____

Gender: Female☐ Male☐ Non-binary☐ Trans☐

Address:_____

Cell Phone Number:_____

MEDICAL HISTORY:

ALLERGIES:

Please list all substances you are allergic to including, but not limited to, foods and medications.

Medication/Food/Other	Reaction	Treatment (if any)

CONDITIONS/DIAGNOSES:

Please list any medical or mental health conditions. If you do not have any, please write NONE.

Name of Condition	Diagnosis Date

MEDICATIONS:

Please list below all medications you are taking. Please indicate the condition for which you are taking the medication. Include frequency and dosage. Please bring the total amount of medication you will need while at your summer program. Columbia Health providers do not prescribe medication for students whose conditions are managed by outside treatment providers.

Medication Name	Condition for the Medication	Dosage and Frequency

If you will need to have Columbia Health store and/or administer any medication for you, please contact Columbia Health Medical Services directly no later than two weeks prior to your arrival to request the necessary approval forms. Columbia Health Medical Services will review every request for feasibility and appropriateness and will notify you before you arrive once a decision has been made. Please see contact information directly below. Columbia Health reserves the right to decline any request that has not followed this process.

To request approval forms for medication administration, contact:
Medical Services, Columbia Health
Columbia University MC 3601
519 West 114th Street
New York, NY 10027
Phone number: 212-854-7426, ext 4
Fax number: 212-854-2477

IMMUNIZATIONS

Students admitted to the summer program are required to provide proof of immunity to Measles, Mumps and Rubella (MMR) by returning the MMR Immunization form (which you will receive via e-mail) to office of Health Services at Columbia University. In addition to providing documentation of immunity to MMR, we recommend that young adults be fully immunized against Hepatitis B and Varicella (Chicken Pox).

HEALTH INSURANCE INFORMATION:

All students are expected to have health insurance coverage, which includes emergency care and major medical coverage for hospitalization in New York State. Students are required to bring proof of insurance coverage with them. Please provide your health insurance coverage information below and a photo copy of the front and back of your card and attach that copy to this form.

Insurance Carrier:_____

Subscriber's name:_____

Relationship to Student:_____

Insurance Policy or Group Number:_____

Insurance Company Telephone Number:_____

IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

Name:_____ Relationship to student:_____

Cell Phone Number:_____ Home Phone number:_____

Address:_____

PARENT/GUARDIAN INFORMATION:

_____ Check here if the same for emergency contact information above

Name:_____ Relationship to student:_____

Cell Phone Number:_____ Home Phone Number:_____

Address:_____

_____

AUTHORIZATION FOR MEDICAL TREATMENT OF STUDENT UNDER 18 YEARS OF AGE

(*Signature of parent or guardian is required if the student will be under 18 years of age on the first day of the program.)*

I authorize and grant permission to Columbia Health to both evaluate and render medical treatment to the student named on this form, including but not limited to, ordering medically necessary tests, administering appropriate medications, providing prescriptions and referrals, and if necessary transporting the student to the hospital for a higher level of care.

Signature:_____ Date:_____

Relationship to Student:_____

AUTHORIZATION TO SEEK MEDICAL ATTENTION FOR STUDENT UNDER 18 YEARS OF AGE

(Signature of parent or guardian is required if the student will be under 18 years of age on the first day of the program)

I authorize the staff of the Barnard Pre-College Programs and any other entity offering educational services in conjunction with the Barnard Pre-College Programs' students to seek emergency medical attention for the student named on this form.

Signature:_____ Date:_____

Relationship to Student:_____