



Tufts Summer Study
 Dowling Hall
 419 Boston Avenue
 Medford, MA 02155
 617-627-2000 phone
 617-627-4691 fax

Health Information & Consent Form

Name of Student _____

Student Date of Birth _____

This form is required in order for staff clinicians at the Tufts University Health Service, or any other medical facility, to render medical services while you attend Tufts.

Student Consent (If student is older than 18 years of age)

I consent to medical care in the Tufts University Health Service or any other medical facility.

Student Date of Birth _____

Student Signature _____ Today's Date _____

Parent/Guardian Consent (If student is 18 years of age or younger)

I, the parent or guardian of the above named student, hereby grant permission to the Director of Tufts University Health Service, or other medical professional, or his/her authorized representative, to furnish such medical care as my son or daughter may require, including examinations, treatment, immunizations, and so forth. This permission is conditional upon the understanding that in the event of serious illness or the need for hospitalization and/or surgery, the Director will use all reasonable efforts to contact me. Failure in such efforts, however, should not prevent the Director from providing such emergency treatment as may be necessary for the best interest of my son/daughter. I understand that I will be responsible for any medical expenses incurred by my son/daughter during this program.

Parent/Guardian Signature _____ Today's Date _____

Relationship to Student _____

Health Insurance Information

Subscriber Name _____ Subscriber DOB: _____

Health Insurance Provider/Company _____

Company Address _____

Policy Number _____ Group Number _____

Emergency Contact Information

Name of Student _____

Student Current Address _____
Street

City State Zip Country

Name of Emergency Contact _____

Relationship to Student _____

Emergency Contact Phone _____

Alternative Emergency Contact Name _____

Relationship to Student _____

Alternative Emergency Contact Phone _____

Medical Profile

1. Do you have any medical problems for which you are receiving medication? Yes No

If yes, complete the following

Diagnosis	Medication(s)
_____	_____
_____	_____
_____	_____
_____	_____

2. Are you allergic to any medicines(s)? Yes No

If yes, list pertinent medicines(s):

3. Are you allergic to anything else? Yes No

If yes, list:

4. Have you had the following?

Measles Yes No

Mumps Yes No

Chicken Pox Yes No

Student Signature (if over 18 years of age) _____ Date _____

Parent/Guardian Signature (if 18 or younger) _____ Date _____