Yale Summer Session Young Writers' Workshop
Health Exam/Record

Physical Exams are Valid for 3 Years from Date of Last Examination

Please Return Completed Form to Yale Summer Session

Name of Participant_____________________________ Date of Birth: _________Phone______________________

Guardian____________________________Address____

Emergency Contact Name____Telephone________________

Date Program Begins______________________________ Date Program Ends______________________________

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TO BE COMPLETED BY MEDICAL PRACTITIONER (Physician, PA, APRN or RN)**:**

Date of Exam: ___/___/___

Check one:
______May participate in all Program activities
______May participate except for: ____
____

Medical information pertinent to routine care and emergencies: _____________________________________
____

Is the Participant taking prescription or over the counter medication(s)? ☐Yes ☐No
If yes, indicate names of medications____
____

Does the Participant have allergies? ☐Yes ☐No Explain: ___________________________________

Does the Participant have a special diet? ☐Yes ☐No Explain: ___________________________________

Does the Participant have special needs? ☐Yes ☐No Explain: ___________________________________

The Participant is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and the National Advisory Committee on Immunization Practices:

	Yes	**No**		**Yes**	**No**
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments:
____
____
____

Print name of medical care provider: ____

Medical care provider's address: ____Telephone Number_____________

Signature of Physician, PA, APRN or RN ____Date: ____________________

Name of Health Insurance Carrier:___________________________**Group or Policy #**___________________________
Yale University does not provide health and accident insurance for Participants, and I understand that the Participant's medical expenses, property loss, or other personal expenditures that result during or from the Program, are to be borne by me and/or the Participant's health insurance provider.

Consent to Emergency Medical Treatment. The health history above is correct as far as I know, and the Participant has permission to engage in all Program activities noted by me and the examining medical practitioner. I grant Yale, its officers, trustees, agents, employees, students, or volunteers ("Released Parties") permission to authorize emergency medical and surgical treatment for the Participant, as they deem appropriate. I understand and agree that the Released Parties assume no responsibility for any injury or damage that might arise out of, or in connection, with such authorized emergency medical treatment.

Printed Name of Parent/Legal Guardian: ____

Signature of Parent/Legal Guardian: _______________________________________ Date: ___________________