COLUMBIA HEALTH

2017 Summer Program
Health Questionnaire

Students: Welcome to your summer program at 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; and **(3)** if you are under 18, written authorization by your parent or guardian for provision of medical treatment. This information will be kept in strictest confidence by the program and shared only when necessary. A copy of this form will remain on file at Columbia Health, and will prepare us to address any medical conditions you might have. Please be sure to complete all relevant sections of this questionnaire. Completed questionnaires should be sent to the admissions office of your summer program.

***** DO NOT MAIL THIS FORM UNTIL ALL INFORMATION IS COMPLETE *****

Name of Your Summer Program______________________________

Your Name______________________ **Date of Birth**____________**Male**____**Female**_____

Columbia UNI______________________ **Columbia ID (10-digitalphanumeric #)**______

______________________ **Address**______________________ **Telephone or Cell Phone Number** ______________

In case of emergency please notify:

Name______________________ **Relationship**______________________

Address______________________ **Home Phone Number**______________________

______________________ **Cell Phone Number**______________________

Business Phone Number______________________

Parent/Guardian Contact Information (if under 18 years of age):

☐ Check here if same as emergency contact information above

Name______________________ **Relationship**______________________

Address______________________ **Home Phone Number**______________________

______________________ **Cell Phone Number**______________________

Business Phone Number______________________

Physician's Contact Information:

Name______________________ **Phone Number**______________________

Address______________________ **Fax Number**______________________

If you are under 18 years of age on the date you seek treatment, you should know that, in most circumstances, Columbia Health will involve your parent(s) or guardian(s) in discussions about your care.

MEDICAL/SURGICAL HISTORY

Please complete the following:

Please list any medical and behavioral health conditions. ☐ NONE

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____

Have you ever been hospitalized (including surgeries)? ☐ Yes ☐ No If yes, please list the date(s) of *all* hospitalizations and the nature of the problem:

____

____

Please list below all medication you are currently taking. Please indicate the condition for which you are taking the medication. Include dosage and frequency.

Medication Trade Name	Generic Name	Associated Health Condition	Dosage and Frequency

Are you allergic to any medications, foods or other substances? ☐ Yes ☐ No If yes, please list below and describe the allergic reaction you have experienced:

Medication	Reaction	Treatment (if any)

Continuing Medication Administration

If you will need to have Columbia Health store and/or administer any medications for you, (such as giving injectable medication), please contact Columbia Health Medical Services directly 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 once a decision has been made. Columbia Health reserves the right to decline any request that has not followed this process.

To request approval forms contact:
ATTN: Medical Record Coordinator
Medical Services, Columbia Health
Columbia University
MC 3601
519 West 114th Street
New York, NY 10027
212-854-7426, ext. 4
FAX 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 the office of Health Services at Columbia University. In addition to providing documentation of immunity to

MMR, we recommend that young adults be adequately immunized against Hepatitis B and Varicella (chicken pox).

Individuals who come from an area where tuberculosis is endemic should have a Tuberculosis Skin Test (PPD) or the IGRA blood test (QuantiFERON Gold or T Spot), and follow the provider's recommendations regarding any **positive result**. For a list of endemic countries go to http://www.stopb.org/countries/tbdata.asp

HEALTH INSURANCE

All students are expected to have health insurance coverage, which includes emergency care and major medical coverage for hospitalization. Students are required to bring proof of insurance coverage with them. Please provide your health insurance coverage information:

Insurance Company ____________________

Subscriber's Name ____________________

Relationship to Student ____________________

Insurance Policy or Group Number ____________________

Insurance Company Telephone Number ____________________

DISABILITY SERVICES

Any student requiring accommodations for a disability should contact Disability Services upon acceptance into the program or no later than June 1.

Contact Disability Services
Phone: 212-854-2388 (Voice/TTY)
Fax: 212-854-3448
Email: disability@columbia.edu

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 Summer Program for High School Students and any other entity offering educational services in conjunction with the Summer Program for High School Students to seek emergency medical attention for the student named on this form.

Signature ____________________ **Date** __________

Relationship to Student ____________________