URBAN SCHOLARS PROGRAM EMERGENCY MEDICAL CARE FORM

Scholar's Last Name _____ First Name _____ Middle _____

Street Address _____Town _____ State ___ Zip Code _____

Birthdate: Month _____ Day _____ Year _____ Age as of September 1, 2020 _____

Scholar's Health Insurance Provider: ☐ Medicaid/Husky ☐ Medicare ☐ No Insurance ☐ Other _____

Insurance Policy Number: _____ Insurance ID: _____

Date of Last Tetanus Immunization: _____ Current Height _____ Current Weight _____

Primary Care Physician: _____ Phone: _____

Physician's Address/City/Zip Code _____

Dentist: _____ Phone: _____

Dentist's Address/City/Zip Code _____

Preferred Medical Facility _____

PERMISSION TO TREAT

I give my consent for the First Aid and CPR certified staff of LifeBridge's Urban Scholar Program to administer first aid and CPR to my child and to contact the above named physician or dentist if my child has a medical emergency. I also give my consent for my child to be transported to the nearest hospital in the event of a medical emergency. I will be responsible for all medical fees.

Connecticut law states that except in the case of an emergency which threatens life or limb, parent or guardian must sign consent to treat for a patient under the age of 18. Please complete this section to allow your child to receive treatment for an accident, injury or illness at a medical facility.

- Program staff will always notify parent/guardian of need for medical care.
- Scholar Health History and Registration Forms will be shared with the Medical Facility staff.

I request and authorize the nearest medical center, and its personnel to deliver medical care to my child. I also authorize LifeBridge Community Services to share Scholar Health History with the Medical Provider. This authorization will expire one year from the date of signature unless otherwise stated.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the Urban Scholar Program Director to order x-rays, routine tests and treatment for me(staff) or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Urban Scholar Program Director to hospitalize, secure treatment for and to order injection and/ or anesthesia and/or surgery for me(staff)/or my child as named above. This form may be photo-copied for use off property.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____ Date _____

URBAN SCHOLARS PROGRAM HEALTH NEEDS FORM

Scholar Name: _____ Date of Birth: _____ /_____ /_____

The following questions are required for ALL Scholars. It is used to identify Scholars who require a plan of care to maintain health and maximize participation in the Urban Scholars Program. A more detailed **Individual Plan of Care for a Child with Special Health Care Needs or Disabilities form** is required for starred * items. The director will work with you to develop the Plan of Care.

PLEASE CHECK ALL THAT APPLY AND COMPLETE APPLICABLE SECTIONS:

☐ My child has a food allergy(s) to: _____

The plan of care is

☐ Strict Avoidance

☐ *Medication as required (example: Epi-Pen).
Please provide the medical provider's order and an Individual Plan of Care form.

☐ Other (please specify): _____

☐ My child has non-food allergy(s) to: _____

The plan of care is

☐ Strict Avoidance

☐ *Medication as required (example: Epi-Pen).
Please provide the medical provider's order and an Individual Plan of Care form.

☐ Other (please specify): _____

☐ *My child requires medication for treatment of: _____
Please provide the medical provider's order and an Individual Plan of Care form.

☐ *My child as a chronic illness or diagnosis of: _____

Please provide an Individual Plan of Care form.

☐ My child has special dietary, dental or oral needs: _____

The plan of care is: _____

☐ My child is ____ hearing or____ vision impaired.

The plan of care is: _____

☐ *My child has cognitive, emotional and/or physical developmental needs related to the diagnosis of: _____

_____

Please provide an Individual Plan of Care form.

Scholar Name: _____ Date of Birth: _____ /_____ /_____

☐ My child has had a serious illness, hospitalization or accident in the last 12 months. Please explain: _____

_____

☐ *My child has required psychiatric counseling/hospitalization. Please explain: _____

_____

Please provide an Individual Plan of Care form.

☐ *Any specific activities to be limited by health care provider's advice. _____

Please provide an Individual Plan of Care form.

☐ Check here to be contacted by First Aider or Director to further discuss and plan for the needs of your child. Please indicate best number or email for contact: _____

☐ **My child DOES NOT require any plan of care for special health care needs or disabilities.**

This health information is correct so far as I know and the person herein described has permission to engage in all prescribed program activities except as noted.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____