# URBAN SCHOLARS PROGRAM EMERGENCY MEDICAL CARE FORM

**Scholar's Last Name _____ First Name _____ Middle _____**

**Street Address _____Town _____ State ___ Zip Code _____**

**Birthdate: Month _____ Day _____ Year _____**

**Scholar's Health Insurance Provider: ☐ Medicaid/Husky ☐ Medicare ☐ No Insurance ☐ Other (list) _____**

**Insurance Policy ID Number: _____ Insurance Group #: _____**

**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 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 Information 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.

**I am signing this form by typing my name below.**

**Parent/Guardian Printed Name _____ Date _____**

# URBAN SCHOLARS PROGRAM HEALTH HISTORY & NEEDS FORM

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

Much of this information 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 Scholar 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. **If any medication is required to be administered at Urban Scholars, both the *Authorization for the Administration of Medication* form and *Individual Plan of Care* forms are required.**

**Please answer these health questions about your scholar.**
For any checked answers, include information about how you manage each checked condition, medications taken, if meds need to be taken or available at Urban Scholars, and other details that will assist us in understanding your Scholar's health needs, etc. Feel free to attach additional sheet(s).

**My Scholar has:**

- ☐ ADHD/ADD
- ☐ Allergy to Food
- ☐ Allergy to Medication
- ☐ Allergy to Other
- ☐ Daily medications (* for meds at program)
- ☐ Asthma*
- ☐ Seizures*
- ☐ Diabetes*
- ☐ Behavior Issues
- ☐ Specific activities to be limited*
- ☐ Chronic Illness (other than asthma)*
- ☐ Hospital or ER visit in the last 12 months
- ☐ Special dietary needs/requests
- ☐ Any Problems with Hearing
- ☐ Any Problems with Vision (including glasses/contacts)
- ☐ Any Problems with Speech
- ☐ Seeing a counselor/therapist (list reason below)
- ☐ Developmental, emotional or physical condition*
- ☐ Required psychiatric hospitalization*
- ☐ **No Health Issues/Concerns**

Is scholar fully vaccinated for Covid? _____Date of last Covid shot _____

☐ Check here to be contacted by First Aider or Director to further discuss and plan for the needs of your Scholar.

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. I give permission for sharing of this information with Urban Scholars staff. I authorize LifeBridge Urban Scholars to contact me via text or email regarding health information.

**Parent/Guardian Signature _____ Date _____**

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