



Summer Youth and Precollege Programs in the Arts
HEALTH FORM
(to be submitted with current immunization form)

Student Legal Name: _____ Student Preferred Name: _____

Program(s) Attending: _____

Date of Birth: _____ Gender: M ___ F ___ Non-Binary ___

Parent/Guardian 1 Name: _____ Parent/Guardian 1 Daytime Phone: _____

Parent/Guardian 2 Name: _____ Parent/Guardian 2 Daytime Phone: _____

Doctor's Name: _____ Doctor's Phone Number: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Circle any that apply (indicate details in the space provided; continue on back of form if necessary)

Allergies – Food:	Allergies – Medication(s):	Allergies – Latex or other:
Allergy – Insect Stings:	Asthma:	Diabetes:
Anxiety/Depression:	ADD/ADHD:	Epilepsy/Seizures:
Other (please explain):		

Does your student currently take prescribed or OTC medication during school hours? Yes _____ No _____

If yes: Provide medication and dosage: _____

Does medication/dosage change during the summer? Yes _____ No _____

If yes: Provide medication and dosage: _____

*if medication is taken to help in a classroom setting, we strongly recommend students continue for our programs

Special Needs: We strive to create the best experience for all our students. Accordingly, special requests will be considered and, when appropriate, we will offer the supports commensurate with the resources available to a voluntary noncredit summer program. Any student who needs special accommodations because of a disability must contact the School of Continuing Education at conted@purchase.edu six weeks prior to the start of the session in which the service is needed. In some instances, as many as six weeks prior notification is required to arrange reasonable accommodations.

Is there is an IEP or Section 504 Accommodation? Yes _____ No _____

If the answer is yes, a current copy of the summary page must also be submitted with this document.

Please provide any other information and/or physical limitations. (Continue on back of form if necessary)

Parent/Guardian Authorization: This health history form is complete and correct to my knowledge and the student named here has permission to participate in all program activities. In the event I cannot be reached in an emergency, I give my permission to emergency services personnel to treat my student as needed, including hospitalization, medication, anesthesia or surgery.

Signature _____ Date _____

**Important: Return the completed form with current immunization form no later than
six weeks prior to the start of the program.**

Email: youth.pre.college@purchase.edu Fax: 914-251-6515

Mail: Youth and Precollege Programs in the Arts, School of Continuing Education, 735 Anderson Hill Road, Purchase, NY 10577