HEALTH SERVICES AT COLUMBIA
Summer Program Health Questionnaire

To the Student: You have been accepted at Columbia University for a summer program. Before you come to campus to begin your program, it is necessary that you supply Health Services at Columbia with: **(1)** Proof of immunity to MMR (form attached), **(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 at Health Services. It will enable us to be prepared to address any special medical problems you might have. Please be sure to complete all relevant sections of this questionnaire. Completed questionnaires should be sent to your program director.

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

Name____________________________________ **Date of Birth**________________ **male**___ **female**____

Address__________________________________ **Last 4 Digits of Social Security Number**____________

____ **Telephone or Cell Phone Number**_________________

In case of emergency please notify:

Name____ **Relationship**______________________________

Address____ **Home Phone Number**_____________________

____ **Cell Phone Number**______________________

Business Phone Number__________________

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

MEDICAL/SURGICAL HISTORY
Please answer the following questions.

Do you have any medical conditions or illnesses of which we should be aware? ☐ Yes ☐ No.
If yes, please list them below:

____

____

____

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

____

Please list below any medications you are currently taking with dosages and frequencies:

Medication	**Dosage**

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

Medication	Reaction

IMMUNIZATIONS
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) and follow the provider's recommendations regarding any positive result.

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 Name:____

Insurance Policy Number:____

Insurance Company Telephone Number:____

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 Health Services at Columbia to administer treatment to the student named on this form.

Signature ________________________________ **Date**_______________

Relationship to student______________________________