ROGER WILLIAMS UNIVERSITY HEALTH SERVICES
Marine Biology Summer Camp (2023) Health Forms

Important instructions for the completion of Summer Camp Health Forms:

1. Parent/Guardian should complete pages 2-4
2. Health Care Provider should complete pages 5-6 and attach immunization record
3. Completed forms, along with the participant's insurance and prescription cards and immunization record should be returned to the Department of Marine Biology no later than May 15, 2023.

*****Students must have all required immunizations BEFORE arriving on campus***

University On-Campus Emergency Number: Public Safety 401-254-3333

Local Area Medical Resources:

Local Pharmacies:

CVS Pharmacy 401-253-8808 State Street, Bristol
CVS Pharmacy 401-253-2050 Metacom Ave, Bristol

Local Walk-In Medical Centers:

Medical Associates of Rhode Island
1180 Hope Street
Bristol, RI 02809; 401-253-8900

Warren Family Medical
851 Main Street
Warren, RI 02885; 401-247-1000

Area Hospitals:

Newport Hospital - Emergency Room
Address: 11 Friendship St, Newport, RI 02840
Phone: (401) 846-6400 Ext.2

Hasbro Children's Hospital Emergency Room
Address: 593 Eddy Street, Providence, RI 02903, Providence, RI 02903
Phone: (401) 444-4000

ROGER WILLIAMS UNIVERSITY

SUMMER CAMP HEALTH FORMS

(Please Print)

PERSONAL INFORMATION

Camp participant: First Name: _____ Last Name _____

Name of Camp: Marine Biology Summer Camp Birth Date: _____

Home Address, City, State, Zip: _____

_____

_____

Home Phone: _____ Camp Participant Cell Phone: _____

Email Contact: _____

PERSON TO BE NOTIFIED IN AN EMERGENCY

#1

Name: _____ Relationship: _____

Address: City: State: Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

#2

Name: _____ Relationship: _____

Address: City: State: Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Insurance Company Name: Policy #: _____

Claims Address: _____

Subscriber Name: _____

Is pre-authorization required? YES _____ NO _____ Phone Number for Pre-authorization: _____

Prescription Plan Name and Number: _____

Phone Number for Prescription Authorization: _____

You must include a copy of your insurance and prescription cards (front and back) with these forms

Camp participant's name: _____

Health History

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THE CAMP PARTICIPANT HAS EXPERIENCED; EXPLAIN AND GIVE DATES AS NEEDED.

Acne / Eczema / allergic skin disease _____

Asthma / Bronchitis / Pneumonia / Tuberculosis _____

Ear Infections /Tonsillitis /Sinusitis / Seasonal allergies _____

Mononucleosis / Liver or spleen injury _____

Heart murmur / Heart condition _____

High blood pressure / Low blood pressure / Phlebitis (blood clot) _____

Appendectomy / Hernia / _____

Diarrhea (chronic) / Blood in the stool / Parasitic infection _____

Hepatitis; Type: A B C / Ulcer / Ulcerative colitis / Crohn's disease _____

Cystitis (bladder infection) / Blood/Protein in urine _____

Nephritis (kidney infection) / Loss of kidney _____

Amenorrhea (missed periods) / Dysmenorrhea (painful periods) _____

Fractured bones / severe sprains / ligament injuries / Back pain / Joint pain _____

Diabetes / Thyroid disease / Anemia / Sickle cell disease or trait _____

Seizures / Severe headaches / Dizzy or fainting spells / Concussion / _____

Depression / Anxiety / Bipolar / ADD / Eating disorders / Counseling: yes / no _____

Head injury / Loss of consciousness / _____

Eye injury / Eye loss _____

If none of the above apply, please check here ( )

Allergies: (food, insects, medication) _____

Have you had Chicken Pox? NO YES Date of disease: _____

Additional comments or problems (Please list any surgery or hospitalizations)

_____

_____

_____

CURRENT MEDICATIONS: (including vitamins and birth control pills)

_____

_____

_____

Camp participant's name: _____

PERMISSION TO ADMINISTER PRESCRIPTION AND OVER THE COUNTER MEDICINES:

Over the counter medicines: I give my permission for my son/daughter to have the following if medically indicated: (Please circle those permitted)

Tylenol Ibuprophen Benadryl Decongestants Bacitracin

Prescription RXs:
Please list all prescribed medicine the student will be taking while at camp. The medicine must be in the original prescription bottle and labeled appropriately with dose and time.

1. _____
2. _____
3. _____

Epi-pen has been prescribed and my child has one in his/her possession and understands how and when to use it. YES NO

PARENT/GUARDIAN SIGNATURE, ACKNOWLEDGEMENT & CONSENT:

The undersigned hereby certifies that:

- The information contained above is accurate and complete.
- I understand that I am responsible for my child's medical expenses and associated costs.
- I release Roger Williams University from any responsibility and liability for my child's injuries, illnesses, medical bills, charges, or similar expenses.
- My son/daughter is in good mental and medical health and is able to participate in the summer camp and associated camp and athletic activities.
- I authorize the nearest or appropriate medical facility to provide routine health care for my child; to order x-rays, tests or treatment; and to release any records necessary for insurance purposes as they, in the exercise of their sole discretion, may deem necessary and appropriate. In the event I cannot be reached in an emergency, I give permission to the camp staff to administer or secure treatment, including surgery or hospitalization, for my child. I give permission to contact my child's medical provider for the purpose of confirming medical conditions/treatments or obtaining medical information to provide appropriate care. This authorization shall be in effect while my child is a participant in the above identified summer camp.

Parent/Guardian Name (Please Print): _____

Parent/Guardian (Signature): _____ Date: _____

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED BY THE RI DEPARTMENT OF HEALTH FOR ALL STUDENTS

** Please attach a copy of the camp participant's immunization record, which must include:

DPT/DT/TDAP	Must have one (1) Tdap & also last dose of Td or Tdap must be within last 10 years.
MMR	Two doses of MMR (Measles, Mumps, Rubella) both given after 12 months of age, or disease confirmed by office record or positive titer.
VARICELLA	One dose after 1 year of age, or two doses after 13 years of age, or disease confirmed by office record or positive titer.
HEPATITIS B	Three doses Hepatitis B vaccine required, or positive titer (or two adult doses between the ages of 11-15)
MENINGITIS	One dose of meningococcal conjugate (MCV4) vaccine is required for students under 18 years of age.
COVID-19	The University requires all students, including summer camp participants, to have completed the primary covid vaccine series (1 vaccine for the J&J vaccine, or 2 vaccines for the Moderna or Pfizer vaccines). Additional boosters are not required, but are highly recommended.

The immunization record for _____ is attached and verified as meeting the above requirements.

Provider Name: _____Phone: _____

Address: _____

Signature: _____ Date: _____

Camp Participant's name: _____

PHYSICAL EXAMINATION

Date of Exam: _____

Height: _____Weight: _____ BMI: _____ Blood Pressure: _____ Visual Acuity: _____ (R) _____ (L)

1. Skin _____
2. Ears _____
3. Eyes _____
4. Nose, throat, teeth _____
5. Neck, thyroid _____
6. Chest, breasts _____
7. Lungs _____
8. Heart _____
9. Abdomen, kidneys _____
13. Lymphatic _____
14. Extremities, back, spine _____
15. Neurological _____
16. Psychological _____

Additional Comments: (prior surgery, serious illness, etc.)

_____

_____

Please list allergies _____

Do the allergies listed above require the use of epinephrine? (Circle one) **YES** **NO**

If yes, has an epi-pen and instruction for use been provided to the camp participant? (Circle one) **YES** **NO**

Based on review of Medical H/P is this camp participant able to participate in camp activities and sports/rigorous play without restriction? YES NO

Provider Name: _____Phone: _____

Address: _____

Signature: _____ Date: _____