



Health History

See pp. 24-27 of Student Handbook for more information about student health at VSA.

Student's Name: _____ Date of Birth: _____
Custodial Parent/Guardian: _____
Preferred Phone Numbers: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

Allergies:

- checkbox This student has no known allergies.
checkbox This student is allergic to the following food(s):
Causes anaphylaxis? Yes No
Describe the reaction if this food is eaten and what is done to manage it:
checkbox This student is allergic to these medications:
Causes anaphylaxis? Yes No
Describe the reaction and how it is managed:
checkbox The student is allergic to the following:
Causes anaphylaxis? Yes No
Describe the reaction and what is done to manage it:

General History: (Circle "Yes" or "No" for each statement)

- Yes No This student has had chicken pox or has received the varicella immunization
Yes No This student has had mononucleosis during the past school year
Yes No This student's hearing is within normal ranges or is corrected by hearing aids
Yes No This student's sight is within normal ranges or is corrected by glasses or contacts
Yes No This student typically sleeps without snoring or sleep talking
Yes No For girls, this student knows about menstruation or has a normal menstrual history
Yes No This student has been advised of the availability/advisability of a meningitis vaccine

Student's Physician: _____ Office Phone: _____
Student's Orthodontist: _____ Office Phone: _____
Student's Dentist: _____ Office Phone: _____
Other: _____ Office Phone: _____

Nutrition:

- checkbox This student eats a wide variety of foods, including meats and vegetables
checkbox This student has the following dietary restrictions (include vegetarian, vegan, kosher, as well as medical dietary restrictions here):

Student's Name: _____

Chronic Health Concerns:

- This student has no chronic health concerns and is capable of full participation in the program.
- This student has the following chronic health concerns (please circle all that apply):

Asthma	Menstrual cramps	Major Surgery
Headaches	Frequent Ear Infections	Addictions
Sleepwalking	Fainting	Eating Disorder
Diabetes	Encopresis	Other:
Bedwetting	Seizure Disorder/Epilepsy	

Medication:

- This student **will not** take any medications while attending VSA.
- This student **will** take the following medications while attending VSA:

Name of Medication	Reasons for Taking It	Side Effects	Dose Given and When
			Breakfast dose: Lunch dose: Dinner dose: Bedtime dose: Other:
			Breakfast dose: Lunch dose: Dinner dose: Bedtime dose: Other:
			Breakfast dose: Lunch dose: Dinner dose: Bedtime dose: Other:

Medication Guidelines:

- Bring enough of each medication to last the entire session.
- Students taking medications for psychiatric reasons should be on a stable medication regime, ideally having been on the same medications(s) at the same dose for the three months prior to a student's arrival to VSA.
- All medications must arrive in appropriately labeled pharmacy containers.
- **Students are not allowed to keep any medications (including over-the-counter medications) in their room.**
- VSA will hold and safeguard all prescription medications in a designated VSA office. It is the responsibility of the student to come to the office to receive his or her medications.
- **Vanderbilt Summer Academy is not responsible for missed doses.**

Medication guidelines continued on page 3.

Student's Name: _____

The following medications are stocked in the VSA office and the Vanderbilt Student Health Center. **Cross out those medications that your student should NOT be given:**

Acetaminophen (Tylenol)	Benadryl Cream	Tinactin
Children's Pepto-Bismol	Ibuprofen (Advil)	Triple antibiotic cream
Benadryl	Cough drops	Chloraseptic Throat Spray

Mental, Emotional and Social Health: (Circle "Yes" or "No" for each statement):

Yes No This student has been diagnosed with ADD or AD/HD (specify): _____
Yes No This student has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder (specify): _____
Yes No This student has an emotional health concern (specify): _____
Yes No During the past academic year, this student has seen or is currently seeing a professional to address mental/emotional concerns (specify): _____

If "Yes" was the answer to any of the four statements above, attach a statement from your student's professional (psychiatrist, physician, counselor) that address the following three things:

1. Describes the concern and the student's management plan (including medication) while in our program.
2. Describes the behaviors that will indicate to our staff that the student needs a professional referral.
3. Provides a recommendation for the student's participation in Vanderbilt Summer Academy.

Has the student had a significant life event that continues to impact the student's life? If so, please provide written information about the event – death of a loved one, divorce, new sibling, family change – its impact on the student's life and care tips for VSA staff:

Insurance Information:

Parents/ Guardians are financially responsible for healthcare costs. All students must have health insurance during their term here. Please see pp. 24 of the Student Handbook for more information.

Insurance carrier or plan name: _____ Group #: _____
Carrier Street Address: _____
City: _____ State: _____ Zip: _____
Carrier Phone Number: _____
Name of Insured: _____ Relationship to Student: _____
Policy Holder's Insurance ID Number: _____

NOTE: Please photocopy the front and back of your health insurance card and mail along with this health form.

Alternative Contact Information:

We will certainly call parents/guardians in an emergency, but we'll also call if we have questions about a student's health. If we cannot reach a parent or guardian, we ask that you provide

Return to Vanderbilt PTY immediately upon receipt and no later than May 8, 2009
Form 5

Student's Name: _____

contact information for someone who knows the student and with whom we can consult. We assume you have spoken to these alternative contacts and they are willing to assist should the need arise.

- 1) Alternative Contact's Name: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Relationship to Student: _____
- 2) Alternative Contact's Name: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Relationship to Student: _____

Special Equipment Needs:

Please provide any additional information about special needs such as elevator/ramp/wheelchair access, equipment to aid sleeping, hearing aids, crutches, etc. that the VSA staff needs to be made aware of:

Note: If students are accustomed to using special equipment (e.g., hearing aids) during the school year, it is highly recommended that they use the same equipment during their stay at VSA.

Vanderbilt University Student Health Reminders:

Vanderbilt University Student Health Center, in the heart of the Vanderbilt Campus, will be open from 8:30 AM until 4:30 PM, Monday through Friday. Clinic visits for minor or acute medical problems and/or injuries will be provided as needed for a **clinic fee**, with the invoice for this *or any other fees* to be paid in full upon student checkout from VSA.

Sample Student Health services that require a charge beyond the clinic fee:

- Prescriptions filled at local or VU Medical Center pharmacies
- Medications sold at the Student Health Center
- Laboratory tests
- Medical and orthopedic supplies
- Referrals to VU Medical Center hospital or clinics (services outside Student Health)
- Allergy or other injections at Student Health

Sample Services not provided for VSA students:

- Health insurance
- Routine Mental Health Care (except for crisis management)
- Management of chronic health problems

Note: *Students must be independent in their daily health care.* Students in the program should not have medical conditions requiring daily ongoing monitoring or day-by-day management by someone other than the student.