NEW YORK INSTITUTE
OF TECHNOLOGY

NYIT Medical History and Release Form

It is requested that the enclosed Health Assessment Form be completely and accurately filled out (by a non-parental health care provider) and submitted to your Program Director ***prior to*** arriving on campus. Immunization information is requested for the public health and safety of the campus and the participants. Without documentation of immunity, participants may be asked to leave campus in the event of an outbreak. New York State law requires meningococcal meningitis vaccination, or documentation of refusal of the vaccine, for all participants. Please review the enclosed information carefully, answer all questions on the forms, and obtain all required vaccinations.

If your son, daughter, or ward is under the age of 18 while at NYIT, it is our policy to secure your consent for medical treatment. By signing the attached consent on the Health Assessment, you will be giving your consent to medical evaluation and treatment necessary to ensure the continued health of the participant. In the event of a major health problem, whenever possible, specific permission will be obtained from you. Therefore, parents of participants under 18 should be sure to include all possible telephone numbers (including cell phones) on the Health Assessment Form, and complete the authorization on the bottom of page one.

International participants *attending NYIT Summer Programs: please review the immunization requirements very carefully with your health care provider. The requirements may differ from the country in which you reside. The requirements are very specific and* ***no exceptions*** *can be made.*

Again, we are pleased that you will be here, and wish you a safe, happy, and healthy learning experience.

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REQUIRED FOR ALL PARTICIPANTS UNDER 18 YEARS OF AGE

This form must be returned to your program director prior to arrival at the college.

Parent/Guardian #1

Name: _____

Address: _____

Cell Phone: _____

Work Phone: _____

Home Phone: _____

Email: _____

Parent/Guardian #2

Name: _____

Address: _____

Cell Phone: _____

Work Phone: _____

Home Phone: _____

Email: _____

PRIMARY PERSON TO CONTACT FOR CONSENT FOR TREATMENT OR IN CASE OF AN EMERGENCY

Name: _____

Relationship to Participant: Check one: □ Parent □ Legal Guardian □ Spouse □ Other

Cell Phone: _____

Work Phone: _____

Home Phone: _____

Email: _____

NEW YORK INSTITUTE OF TECHNOLOGY

NYIT PROGRAMS HEALTH FORM

(TO BE COMPLETED BY MEDICAL PROVIDER)

REQUIRED MEDICAL HISTORY

Participant Name: _____

Date of Birth: _____

Allergies

Medications

Please list all current medical problems and related treatments
Special Accommodations Needed? YES NO Please explain.

Provider Name: _____

Provider Signature / Stamp: _____

Date: _____

Address: _____

Phone: _____