



HEALTH HISTORY FORM FOR ALL USER GROUP/VISITING RESEARCHER PARTICIPANTS @ SHOALS MARINE LABORATORY FOR 5 DAYS OR MORE. Thank you for taking the time to provide us with your personal, health and insurance information. The information you provide is intended for use by Shoals Marine Laboratory, Cornell University, the University of New Hampshire and appropriate medical personnel only. This information will not be released outside of SML, Cornell, UNH without your written permission. Please **PRINT** all of your responses!

Please complete and return this form within 10 business days of receiving it from SML:

FAX: (603) 430-5221

eMAIL: shoals-lab-east@cornell.edu

MAIL: Shoals Marine Laboratory, 400 Little Harbor Road, Portsmouth, NH 03801

PERSONAL INFORMATION SECTION (required)

Name of participant: _____ Date of birth: _____

Name of parent, legal guardian or emergency contact: _____

Home or Emergency phone (s): _____

Participant cell phone: _____

Mailing address: _____

INSURANCE INFORMATION SECTION (required)

Name of Insurance Company: _____ Phone: _____

Address of Insurance Company: _____ Policy number: _____

Policyholder's name: _____ Relationship to policyholder: _____

MEDICAL INFORMATION SECTION (required)

Please indicate below any existing or previous medical conditions (physical and/or mental) that may require special attention (e.g. epilepsy, allergies, asthma, handicap, anxiety, depression, etc.). Use the back of this page if needed.

Please list any prescriptions that you will be bringing with you (be sure to bring a sufficient supply — see below):

Please let us know if any prescriptions or other medications you are bringing (specify) need to be refrigerated:

Will any of these prescriptions (please specify) need to be administered by a nurse or doctor*? Check one: Y N

**If so, we will have to notify medical personnel on neighboring Star Island. Your signature on page 2 will allow us to do so.*

IMPORTANT: In the event that any of your prescriptions need to be re-filled, or a **new** prescription is needed because of an **emergency**, prescriptions need to be called into: CVS Pharmacy, 674 Islington Street, Portsmouth, NH 03801; 603-431-0234. Prescription payments must be prepaid by credit card, directly to the pharmacy prior to pick-up by an SML staff member. You will need to indicate to the pharmacy that SML staff has your permission to pick up the prescription.

Allergies to medications: _____

Other allergies (e.g. bee stings, etc.): _____

Food related allergies: _____

Date of most recent Tetanus Immunization (required by Cornell University Health Services): _____

If enrolled for OVER 6 credits the dates of your most recent Measles/Mumps/Rubella Immunizations are required by Cornell University Health Services. Provide dates here OR include a copy of your immunization record with this form.

Measles: _____ Mumps: _____ Rubella: _____

Primary Physician Name and Phone: _____

AUTHORIZATION FOR MEDICAL TREATMENT AND PERMISSION TO DISCLOSE MEDICAL RECORDS

I hereby authorize a staff representative of the Shoals Marine Laboratory in Maine to act on my behalf in the event that I become ill or injured and are unable to provide informed consent for medical treatment. I further authorize a Shoals staff representative to administer or secure proper emergency treatment, including x-ray, examination, anesthetic, medical, surgical, or treatment, and /or hospital care, to be rendered under the supervision and on the advice of a licensed physician or surgeon as appropriate, during the period the registrant is enrolled in Shoals Marine Laboratory’s summer program. In the event of a medical emergency, SML will make a good faith effort to contact a parent, legal guardian or emergency contact as soon as possible. I understand that it may be necessary for SML to disclose my medical records and personal information to SML staff members and to anyone involved in my medical care that needs the information (e.g., physicians, hospitals, emergency personnel, or other persons or entities involved in providing medical care or assistance) on a reasonable need-to-know basis.

Participant signature (date)

Print participant name

Parent/Guardian signature (required if participant is a minor/under 18) (date)

Print Parent/Guardian name (required if participant is a minor/under 18)

AUTHORIZATION FOR DISPENSATION OF “OVER THE COUNTER” MEDICATION TO MINORS (under 18):

I hereby authorize a staff representative of the Shoals Marine Laboratory to provide over the counter medication in the event of any minor discomfort that should arise while at SML, e.g. Tylenol (or a generic brand) for a headache, Pepto Bismol (or a generic brand) for a stomach ache, Sudafed (or a generic brand) for a runny nose, Bonine (or a generic brand) for motion sickness, etc.

Parent/Guardian signature (required if participant is a minor/under 18) (date)

Print Parent/Guardian name (required if participant is a minor/under 18) (date)