

RISD Fusion Arts Exchange

Please complete both sides of this form and mail to:

RHODE ISLAND SCHOOL OF DESIGN

HEALTH SERVICES

Two College Street
Providence, RI 02903 USA
Phone 401.454.6625 Fax 401.454.6628 email: health@risd.edu

HEALTH FORM

All RISD Summer Students must complete this form. Final registration is not complete until this card is completed and returned to Health Services. If you receive this form after May 1, you MUST complete and submit it by June 1st.

STUDENT INFORMATION *Please type or print clearly*

Student's Name: Last First Middle

Permanent Address Date of Birth Age

City State Country Zip Code

Male

Female

Home Telephone ()

Cell ()

HEALTH HISTORY

Measles/ Mumps/ Rubella Date of Dose 1 Date of Dose 2

Date of last Tetanus Booster Tuberculosis, PPD Result Date

Please check all that apply:	Yes	No	Have you ever had:	Yes	No
Is your health generally good?	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Have you been treated for psychological distress?	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a physician or therapist?	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescribed medications?	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe: _____			Measles	<input type="checkbox"/>	<input type="checkbox"/>
_____			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe _____			Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
_____			Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious operation?	<input type="checkbox"/>	<input type="checkbox"/>	Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe _____			Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
_____			Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
For females:			Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced menstrual problems?	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Drug Allergies			Serious Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list _____			Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
_____			Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Other Allergies					
If yes, please list _____					

LIFE THREATENING ALLERGIES: _____ EpiPen: Yes No

Signature of Physician _____ Date _____

Print Physician name _____ Telephone _____ Fax _____

Physician address _____

STUDENT INFORMATION

Name _____
Last First

PARENT OR GUARDIAN INFORMATION

Name Relationship to Student

Address

City State Country Zip Code

Home Telephone Business Phone Cell Phone Fax

EMERGENCY CONTACT (To be contacted if parent or guardian cannot be reached. This information must be different from the Parent information)

Name Relationship to student

Home Phone Business Phone Cell Phone Fax
