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20 West Canal St., Suite C5

**GIV Summer Institute 2020**

**Health Care Provider Form**

Winooski, VT 05404

Phone: 802-865-4448

Fax: 802-865-4442

[www.giv.org](http://www.giv.org)

**There are two Health Forms to complete.**

**This one should be completed by your health care provider.**

**The other is online to be completed by parents/guardians.**

The flip side of this page needs to be completed and signed by your Health Care Provider. If you haven’t seen your HCP for a while, that may necessitate an appointment. If so, schedule your appointment right away so that your provider can send the form back to us on time.

The “Health Information and Authorization Form (Parent)” is for parents/guardians to complete. It is available online in your student’s application account. Visit [www.giv.fluidreview.com](http://www.giv.fluidreview.com) to complete this form by May 15th.

Our mailing address is: The Governor’s Institutes of Vermont, 20 West Canal St., Suite C-5, Winooski, VT 05404. If you have any questions or need assistance with anything, please do not hesitate to call us at (802) 865-4448 or send an email to [forms@giv.org](mailto:forms@giv.org). We are here to make the best possible experience for your child.

Be sure to turn the page and send the other side of this form to your Health Care Provider

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**GIV Summer Institute 2020**

**Health Care Provider Form**

**\*\*This form must be completed and signed by your health care provider\*\***

Please submit the fully completed form before ***May 15th*** or we may be unable to hold a place for your student. Questions? Email us at [forms@giv.org](mailto:forms@giv.org) or call (802) 865-4448.

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Institute Attending**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH CARE PROVIDER (MD, NP, PA)**

**STATEMENT OF HEALTH**

This form ***must*** be received at the GIV office by ***May 15th*** to ensure the student can participate.

To the best of my knowledge, the student named above is in good physical and mental health and can safely participate in the Governor’s Institutes, an overnight, residential 5 to 14 day program which may include intensive study, outdoor sports, activities, swimming, dancing, hiking, etc.

\_\_\_ No restrictions

\_\_\_ Medical restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Print Health Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_