



Originally Issued: August 20, 2018
Reviewed: October 15, 2020
Reviewed: September 30, 2022

WAIVER AND CONSENT FOR MEDICAL TREATMENT AND MEDICATION ADMINISTRATION

The information requested herein is intended to help inform program staff of any pre-existing medical conditions of the participant. This information is confidential and will only be shared with your permission. This information is needed in order to provide and/or seek appropriate treatment for the participant. If participant has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. The medical information disclosed will not be used by program staff to determine the participant's ability to safely participate in activities. You, as participant, or parent/legal guardian understand that the final determination about whether to participate is the responsibility of you and your physician.

Accurate medical information must be provided. If participant has any medical issue that is not requested below, but which you think is important, please include that information. It is recommended that you consult with a physician prior to participating in the program. If you are uncertain about any preexisting medical conditions, it is your responsibility to consult with your own physician prior to participating in this Program. You understand that, if Participant chooses to participate in activities, s/he does so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of yourself, Participant, and your physician.

By signing your name to this waiver and consent, you acknowledge your agreement to the terms and conditions contained therein and you certify that all responses made herein are complete, true, and accurate.

You understand that the University does not offer an excess medical insurance policy for participants to cover medical expenses for injuries/accidents that occur in the course of the program's activities. Medical expenses that are declined for payment through the participant's personal insurance become the responsibility of the participant's parent/guardian.

I. PROGRAM/CAMP INFORMATION

Program/Camp Name:

Date(s):

Time(s):

Location:



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II. GENERAL INFORMATION

Participant Name:

Address:

City/State/Zip:

Home/Cell Phone:

Work Phone:

Date of Birth:

Gender:

Male

Female

Parent/Legal Guardian Name:

Please list **two** emergency contacts:

Contact #1

Name:

Home Phone #

Work Phone #

Cell Phone #

Relation:

Contact #2

Name:

Home Phone #

Work Phone #

Cell Phone #

Relation:

Please answer all of the questions. If you answer yes to any of the questions, please explain as indicated.

Physician's Name:

Phone Number:

Date of most recent tetanus toxoid immunization:



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Do you have health/accident insurance: Yes No

If yes, please provide:

Insurance Company Name/Address:

Policy #:

Check appropriate response and explain as appropriate:

Does participant have any limiting medical conditions that you or your doctor feel would limit camp participation? If yes, explain. Yes No

Is participant currently taking medication that may interfere with ability to safely participate in the program? If yes, explain. Yes No

Does participant have a history of allergies or reactions to medications, insect stings, or plants? If yes, explain. Yes No

Does participant have a history of, or currently suffering from, medical condition(s) with which we need to be aware? If yes, explain. Yes No

Parent/Guardian Name

Parent/Guardian Signature

Date

III. WAIVER AND CONSENT FOR MEDICAL TREATMENT

I, the undersigned parent/guardian, do hereby grant permission for my minor child/ward to receive necessary medical treatment, and give permission for program staff to seek treatment for said minor child/ware, in the event of an injury or illness while at the University during the period of the program.



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Further, I accept responsibility for full payment of such medical treatment not covered by insurance. I hereby hold the University and its representatives harmless in the exercise of this authority.

Parent/Guardian Name

Parent/Guardian Signature

Date

IV. AUTHORIZATION FOR MEDICATION ADMINISTRATION

A. Over-the-Counter (OTC) Medication

Over-the-Counter (OTC) medication may at times need to be administered, if approval is indicated by the participant's parent/guardian. If appropriate, please complete the following.

I hereby authorize the following medications may be given to participant if the need arises. You may only dispense those indicated as directed.

Ointments for minor wound care, first aid (antiseptic, anti-itch, anti-sting, antibiologic, sunburn)

Tylenol/Acetaminophen

Ibuprofen.

Throat Lozenges and/or spray as directed for sore throat.

Kaopectate or Imodium for diarrhea

Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea

Rolaids or Tums for acid reflux, heartburn or indigestion

Benadryl for swelling, hives, allergic reaction

Actifed or Sudafed as directed for nasal congestion or allergy relief



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Visine or other eye drops for minor eye irritation

Medicated lip ointment for dry, chapped lips, lip blisters or canker sores

Swimmer's ear drops

Hydrocortisone ointment for mild skin irritations, poison ivy, and insect bites

Medicated powder for skin irritation

Robitussin or other cough syrup

Calamine lotion for bug bites and poison ivy

Sunscreen

Bug Repellent

Other over-the-counter medication:

Parent/Guardian Name

Parent/Guardian Signature

Date



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B. Prescription Medication (Self-Administration)

Self-administration of prescription medication requires the written authorization of participant's parent/legal guardian. This form must be completed and signed in order for the participant identified to self-administer prescription medication during the program identified above.

_____ No, my child does not need to take any prescription medication during the program.
(Signature Required)

Parent/Guardian Name

Parent/Guardian Signature

Date

Please complete the following if participant needs to take a prescription medication during the program.

_____ Yes, my child will need to take a prescription medication during the Program.
(Signature Required)

Parent/Guardian Name

Parent/Guardian Signature

Date

NOTE: A separate form must be completed for each medication to be administered.

All prescription medications must be brought to the program under the condition that participant can self-manage care and delivery of medication. Prescription medication must be in its original container labeled with the minor's name, medication name, dosage, and time/frequency of administration. This includes, but is not limited to, self-management and safe-keeping of epi-pens and asthma inhalers.



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AUTHORIZATION FOR SELF-ADMINISTRATION FOR PRESCRIPTION MEDICATION

Medication Name: _____ Dose: _____

Time/Frequency of Administration: _____

Medication shall be administered from (date): _____ to _____

Special storage requirements: _____

Prescribing health professional's name: _____

Condition(s) for which medication is administered: _____

Specific directions (e.g., empty stomach, with water): _____

If PRN, frequency _____ For what symptoms: _____

Relevant side effect(s): _____

Is patient capable of self-managed care: YES NO