Oklahoma State University Youth Program/Camp Medical Information and Release Form

PROGRAM/CAMP INFORMATION

Program/Camp Name: _____

Date(s): _____ **Time(s)**: _____

Location: _____

As a student, parent or guardian I understand that the information requested on this form is intended to help inform program staff of any pre-existing medical conditions. If Participant has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. This information will be kept in strict confidence and will only be shared with your permission to pertinent camp staff. Oklahoma State University requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment for the Participant. You are accountable for providing an accurate medical history. Final determination about whether to participate is the responsibility of you and your physician. If Participant has any medical issue that is not described below, but which you think is important, please include that information. If you are uncertain about any preexisting medical conditions, it is your responsibility to consult with your physician prior to participating in this program. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated.

I understand that Oklahoma State University does not offer any form of insurance for participant while participating in the Program.

PART 1. GENERAL INFORMATION

Participant Name _____

Parent/Legal Guardian Name (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____/_____/_____ Gender M _____ F _____

Please list two emergency contacts:

_____ _____ _____

Emergency Contact #1 Name | Home Phone # | Work Phone # | Cell Phone # | Relation

_____ _____ _____

Emergency Contact #2 Name | Home Phone # | Work Phone # | Cell Phone # | Relation

PART 2. MEDICAL INFORMATION

Physician's Name _____ Phone Number _____

Date of most recent tetanus toxoid immunization _____

Do you have health/accident insurance? (Check one) YES NO

If yes, please indicate policy number, name and address of insurance company.

Company Name / Address _____ Policy # _____

For the following, check the box for the appropriate response. If you answer yes to any questions, please explain.

Does participant have any limiting medical conditions that you or your doctor feel would limit camp participation? If yes, identify and explain: YES NO

Is participant currently taking medication that may interfere with ability to safely participate in Program? If yes, please indicate the medication and the condition being treated: YES NO

Does participant have a history of allergies or reactions to medications, insect stings, or plants? If yes, please explain: YES NO

Does participant have a history of food allergies? If yes, please explain: YES NO

Does participant have a history of, or currently suffer from, medical condition(s) with which we need to be aware? If yes, please explain: YES NO

PART 3: AUTHORIZATION FOR MEDICAL CARE

Unless prior arrangements have been made, medical needs will be handled through University Health Services or Stillwater Medical Center. In cases where medical attention is necessary, parents will be contacted for approval when possible. However, before medical treatment can be provided, we are required to have a medical release signed by the parent/guardian.

Participant has my permission to receive medical attention in the event of illness or medical emergency while participating in this Program. I will assume the financial responsibility for any cost of health care for my child that may occur during this Program.

As a participant, parent, or guardian I understand and acknowledge that my failure to disclose relevant information may result in harm to Participant and/or others during this Program. By signing my name I represent and warrant that I have provided all materials and important information to Oklahoma State University pertaining to my Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify Oklahoma State University of any changes in the mental, physical or medical condition of the Participant prior to the scheduled Program.

By revealing or disclosing the above medical information it will not be used by Oklahoma State University personnel or employees to determine Participant's ability to participate safely in activities. I understand that, if Participant chooses to participate in activities, he/she does so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of myself and Participant.

Participant Name_____ **Parent/Guardian Name** _____

Participant Signature_____ **Parent/Guardian Signature** _____

Date_____ **Date** _____

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 18.

Parent/Guardian Authorization, Waiver and Consent for Over-the-Counter Medication Form

(check box) **NO, Participant is not allowed to take over the counter (OTC) medication at camp/program.** *(skip to the next form for prescription medication)*

(check box) **YES, Participant is allowed to take over the counter (OTC) medication at camp/program. If Yes, please sign below.**

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay. **Note: Unless we have parental authorization, we cannot administer ANY medications.** I hereby authorize that the following medications may be given to Participant if the need arises. You may dispense only those checked.

_____ Ointments for minor wound care, first aid as directed. (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
_____ Tylenol/Acetaminophen as directed.
_____ Ibuprofen as directed.
_____ Throat lozenges and or spray as directed for sore throat.
_____ Micatin or anti-fungus treatment as directed for athlete's foot.
_____ Kaopectate or Imodium for diarrhea as directed.
_____ Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea as directed.
_____ Rolaids or Tums for acid reflux, heartburn or indigestion as directed.
_____ Benadryl for swelling, hives, allergic reaction, as directed.
_____ Actifed or Sudafed as directed for nasal congestion or allergy relief per instructions.
_____ Visine or other eye drops for minor eye irritation.
_____ Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
_____ Swimmer's ear drops as directed.
_____ Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.
_____ Medicated powder for skin irritation as directed.
_____ Robitussin or other cough syrup as directed.
_____ Calamine lotion for bug bites and poison ivy.
_____ Sunscreen
_____ Bug repellent
_____ Other (list any other approved over-the-counter drugs) _____

Program staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above. I understand that such administration will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the student's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless the Program Staff, Oklahoma State University, its Board of Regents, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child being administered the above indicated over- the-counter medications. I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at the above referenced program.

Over the Counter Medication Form Parent/Guardian Signature_____
Date _____

Parent/Guardian Authorization, Waiver and Consent for Self-Administration of Prescription Medication Form

(*check box or button)* **No, my child does not need to take any prescription medication while at the Program.** *(skip to the end of form).*

(check box or button) **Yes, my child will need to take prescription medication while at the Program. If yes, please complete the following questions. A parent or guardian must sign this form for a minor under the age of 18.**

This form must be completed fully in order for participants to self-administer required medication. A new medication administration form must be completed for each Program attended by the participant, for each medication, and each time there is a change in dosage or time of administration of a medication. Self-medication requires a parent signature.

All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so at camp by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the participant will be attending the Program.

Medication Name:_____Dose:_____

Condition for which medication is being administered: _____

Specific Directions (e.g., on empty stomach/with water, etc.): _____

Time/frequency of administration i.e. as needed or specific times during the day: _____

Relevant side effects:_____

Medication shall be administered from (date)_____to_____

Special Storage Requirements:_____

Is the participant capable of self-managed care? (Insert check boxes please) YES NO

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the Program Staff, Oklahoma State University, its Board of Regents, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child's self-administration of prescribed medication(s). *I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced Program.*

Prescription Medication Form Parent/Guardian Signature _____

Date _____