University of Toledo
Youth Program/Camp Medical Information and Release Form
Self-Administration of Prescription Medication Form
Authorization, Waiver and Consent for Over-the-Counter Medication Form

(Enter N/A in fields that are not applicable)

PROGRAM/CAMP INFORMATION

Program/Camp Name: _____ (hereafter "Program")

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.*** The University of Toledo 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 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 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 this 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. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated. Use back and/or additional paper if needed.

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

PART 1. GENERAL INFORMATION

Participant Name _____ (hereafter "Participant")

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

It is recommended that Participant consult with your physician prior to participating in this 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. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated. Use back and/or additional paper if needed.

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 # _____

PLEASE ENCLOSE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD WITH THIS FORM

For the following, check appropriate response and explain as appropriate:

Does participant have any limiting medical conditions that you or your doctor feel would limit camp participation? ☐ YES ☐ NO
Identify and explain:

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

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

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

PART 3: AUTHORIZATION FOR MEDICAL CARE (please complete if applicable)

Unless prior arrangements have been made, medical needs will be handled through the University of Toledo 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. The hospital will not perform services unless this form is presented at the time of treatment.

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 the University of Toledo pertaining to my Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify the University of Toledo of any changes in my mental, physical or medical condition prior Participant's scheduled Program.

By revealing or disclosing the above medical information it will not be used by University of Toledo 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 do 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 19

PART 4: PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION (please complete if applicable)

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 licensed health care authorization and signature, *and* parent signature.

☐ **No, my child does not need to take any prescription medication while at the Program.**

☐ **Yes, my child will need to take prescription medication while at the Program.**

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.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name:_____ Dose: _____

Condition for which medication is being administered: _____

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

Time/frequency of administration: _____

If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: _____

Medication shall be administered from (date)_____ to _____

Special Storage Requirements: _____

Is the participant capable of self-managed care? ☐ YES ☐ NO

Prescriber's Name/Title:_____ Prescriber's Place of Employment: _____

Telephone:_____ Fax: _____

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medication(s).

Prescriber's Signature:_____ Date: _____

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, University of Toledo, its Board of Trustees, 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.***

Parent/Guardian Name_____

Parent/Guardian Signature_____ Date _____

PART 5: PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR OVER-THE-COUNTER MEDICATION (please complete if applicable)

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. The University of Toledo, its Board of Trustees, 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.

Parent/Guardian Name_____

Parent/Guardian Signature_____ **Date** _____