# THE UNIVERSITY OF SOUTHERN MISSISSIPPI - YOUTH PROGRAM/CAMP
## WAIVER AND CONSENT FOR MEDICAL TREATMENT, SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION, AND OVER-THE-COUNTER MEDICATION

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**PROGRAM/CAMP INFORMATION**

Program/Camp Name: _____

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

Location: _____

The information requested on this form is intended to help inform program staff of any pre-existing medical conditions of participant. ***This information will be kept in strict confidence and will only be shared with your permission.*** The University requests the information below so that, in case of emergency, it will have accurate information so that it can provide and/or seek appropriate treatment for Participant. If Participant has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. The requested medical information disclosed will not be used by the University personnel or employees to determine Participant's ability to participate safely in activities. You, as participant, parent or guardian understand that the **final determination about whether to participate is the responsibility of you and your physician**.

You are accountable for providing an accurate medical history. 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. You 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 yourself, Participant, and your physician.

By signing your name under Medical Information, you acknowledge your agreement to the terms and conditions contained therein and you certify that all responses made on this form are complete, true, and accurate.

***You understand that the University does 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 and/or through the excess policy become the responsibility of the participant's parent/guardian.***

## PART 1. GENERAL INFORMATION

Participant Name (hereafter "Participant") _____

Parent/Legal Guardian Name (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Home or Cell 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? (circle one): YES NO

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

Company Name / Address _____ Policy # _____

**For the following, circle 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
If yes, 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:

**Parent/Guardian Name** _____ **Parent/Guardian Signature** _____

**Participant Signature** ***(if 18 or older)***_____ **Date** _____

## PART 3: WAIVER AND CONSENT FOR MEDICAL TREATMENT

I, the undersigned parent/guardian, do hereby grant permission for my son/daughter/ward to receive necessary medical treatment, and give permission to The University of Southern Mississippi, through its representatives, to seek treatment for said son/daughter/ward, in the event of an injury or illness while at the University during the period of the program.

Furthermore, 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** _____

**Participant Signature** ***(if 18 or older)***_____ **Date** _____

## PART 4: AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

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 participant'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 University and any of its representatives, employees or 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 participant named above, including the administration of medication at the above referenced program.

**Parent/Guardian Name _____** **Parent/Guardian Signature _____**

**Date _____**

## PART 5: AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

This form must be completed fully in order for the participant identified above to self-administer prescription medication during the program identified above. A separate form must be completed for **each** medication to be administered. Self-administration of medication requires the written authorization (below) of Participant's parent or legal guardian.

_____ **No, my child does not need to take any prescription medication during the Program.**
***(Please stop and sign the form at the bottom of the page)***

_____ **Yes, my child will need to take a prescription medication during the Program.**
***(Please fill out the rest of this form and sign at the bottom of the page)***

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 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.

### AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication name:_____ Dose:_____

Condition(s) for which medication is being administered: _____

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

Time/frequency of administration: _____

If PRN, frequency: _____

If PRN, for what symptom(s): _____

Relevant side effect(s): _____

Medication shall be administered from (date) _____ to _____

Special storage requirements:_____

Is Participant capable of self-managed care: YES NO

Prescribing health professional's name: _____

**I hereby authorize and recommend Participant to self-administer the above-described medication. I hereby affirm that Participant has been instructed in the proper self-administration of the above-described medication.**

**Parent/Guardian Name** _____ **Parent/Guardian Signature** _____

**Date** _____