Youth Program Medical Information Form

Participant Name: _____ **Age:**_____

Program/Activity Name: _____**Program Date:**_____

Instructions

The University of Alabama requests the information on this form so that, in case of emergency, we will have accurate information to assist with providing or securing appropriate medical assistance for our participants. It is recommended that you consult with a physician prior to participating in this program. If the participant has a pre-existing medical condition, participation in any strenuous activity may not be recommended. You are accountable for providing an accurate medical history, but final determination about appropriateness of participation is the responsibility of you and your physician.

Please answer all questions below. If the participant has any medical issue that is not specifically requested below, but which you think is important, please include that information in Section IV. If you answer yes to any of the following, please explain as indicated.

Parent/Guardian Information

Name of Parent/Legal Guardian: _____

Address: _____

City: _____State: _____Zip: _____

Primary Phone Number: _____Alternate Phone Number: _____

Emergency Contact Information

Primary Person to notify in case of emergency:_____Relationship:_____

Contact's Phone Number(s): (____) _____, (____) _____

Secondary Person to notify in case of emergency:_____Relationship:_____

Contact's Phone Number(s): (____) _____, (____) _____

Family Physician:_____Phone Number: (____) _____

Insurance Provider:_____Phone Number: (____) _____

Insurance subscriber name: _____Subscriber date of birth: _____

Policy Number: _____

(Please attach a copy of the front and back of your insurance card with this form.)

I understand that The University of Alabama does not offer any form of health, liability, or other insurance coverage for participants. (Please initial: _____)

Medical Information

Are all immunizations up to date?____Yes ____ No Date of last tetanus shot:_____

Youth Program Medical Information Form

Please list any current medical concerns or medical history we need to know about your child: (Ex. past injuries, current conditions, physical limitations, etc.) _____

_____

If your child has any limiting medical conditions that you or your doctor feel could impact participation in this program, please explain. _____

_____

List any allergies: (Ex. medications, bee stings, food, latex, plants, etc.)_____

_____

Explain any accommodations that your child needs to enable them to safely participate in the program/activity: (Attach additional information, if necessary.)_____

_____

_____

Additional Information

Please provide any additional information or explanation that you feel could be relevant or beneficial for our staff to know in supporting your child during this program. (Attach additional information, if necessary.)

_____

_____

_____

Authorization for Medical Care

I understand that my child is voluntarily participating in a program/activity at The University of Alabama. By signing this form, I hereby acknowledge that all information is accurate and current, that any activity restrictions, allergies, and medications are listed on this form, and to the best of my knowledge, my child is capable of participating safely in this program/activity. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program/activity. I agree to notify the program/activity of any changes in my child's mental, physical, or medical condition before the program/activity begins.

In the case of accident or illness, I hereby authorize the program/activity staff to administer or seek medical treatment for my child, as they see fit, including routine first aid care or emergency medical treatment. I will assume the financial responsibility for any costs associated with health care for my child that may occur during this program. I hold harmless and agree to indemnify the program/activity, The University of Alabama, its agents, and the Board of Trustees from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment. I acknowledge that I am solely responsible for any hospital or other costs arising out of any bodily injury or property damage sustained through my child's participation in such voluntary program/activity.

Signature of Parent/Guardian:_____ Date:_____

Parent/Guardian Name:_____

Youth Program Medication Management Form

Instructions

Prescription or over-the-counter (OTC) 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 medications will be secured by program staff and made available to participant for self-administration as authorized in writing by the participant's parent/guardian. It is the participant's responsibility to come to get their medications, but program staff will make every effort to remind them as needed. If the participant is unsure of the medication to take or the correct dosage, program staff will contact the parent or guardian for clarification.

Medication must be in its original container and all labels must be intact with instructions clearly legible. Prescription medications must be labeled by the pharmacist or prescriber, with the name, address and phone number for pharmacist or prescriber. It is advised that containers hold only the amount required for the time the participant will be attending the Program. If a tablet should be cut in half, this should be done before the submitting medication to the Program. Please send medicine cups for liquid medications.

All medications for a single participant should be stored in a plastic bag labeled with the participant's name and date of birth. All medications and medication bags will be returned to the participant's parent/guardian when the program is over.

This form must be completed fully in order for participants to self-administer required prescription or OTC medication. A new Medication Management form is required for each program attended by the participant, each medication, and each time the is a change in dosage or time of administration of a medication.

Note: Unless we have prior parental authorization, we cannot provide ANY OTC medications.

Youth Program Medication Management Form

Participant Name: _____

Program/Activity Name: _____ **Program Date:** _____

Medication Information

Medication Name: _____ Dose: _____

Condition for which medication is being administered: _____

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

_____

Time/frequency of administration: _____

If taken as needed, frequency: _____

If taken as needed, for what symptoms: _____

Relevant side effects: _____

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

Special Storage Requirements:

Is refrigeration required? ___Yes ___No

Prescriber's Name/Title: _____

Prescriber's Place of Employment: _____ Telephone: _____

If your child requires any assistance with their medications, please explain: _____

_____

Authorization

- I authorize and recommend self-administration by my child for the above medication. *(Please initial: _____)*
- I also affirm that they have been instructed in the proper self-administration of the prescribed medication by their attending physician. *(Please initial: _____)*
- I shall indemnify and hold harmless the Program Staff, The University of Alabama, 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). *(Please initial: _____)*

Signature of Parent or Guardian: _____ Date: _____

Parent or Guardian Name: _____

Work Phone: _____ Cell Phone: _____