

**AUBURN UNIVERSITY OUTREACH PROGRAM OFFICE
GRANDCHILD HEALTH AND EMERGENCY (CALLAWAY) FORM
AUBURN UNIVERSITY INTERGENERATIONAL ELDERHOSTEL INFORMATION**

Program Number and Name: 2532 Greatest Show on Earth! Circus, Nature, Sports Adventures at Callaway

Circle Date of Program: 6/8-6/13 6/22-6/27 7/6-7/11

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. AS A CHILD'S PARENT/LEGAL GUARDIAN, I UNDERSTAND THAT:

The information requested on this form is intended to help inform our staff of any pre-existing medical conditions. If your child 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 only shared with your permission.* The Auburn University Outreach Program Office requests the information below so that, in case of an emergency, you have provided us with accurate information about your child so that we can provide and/or seek appropriate treatment. You are accountable for providing an accurate medical history. *Final determination about whether to participate is the responsibility of you and your physician.* If the child has any medical issue that is not requested below, but which you think is important, please include that information.

PART 1. GENERAL INFORMATION

Child's Name _____ Email Address: _____

Child's Date of Birth ____ / ____ / ____ Parent/Legal Guardian's Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Gender M ____ F ____ Name Child Prefers on Name Tag _____

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 you consult with your physician prior to child's participation in this Auburn University Intergenerational Elderhostel 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 Intergenerational Elderhostel 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: (_____) _____

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 company. Please also include a front and back copy of your insurance card:**

Does your child have any limiting medical conditions that you or your doctor feel would limit participation in the Intergenerational Elderhostel? (circle one)Yes No
If yes, identify and explain:

Is the child currently taking medication that may interfere with his/her ability to safely participate in the Intergenerational Elderhostel? (circle one)Yes No
If yes, please indicate the medication and the condition being treated:

Does the child have any allergies or reactions to medications, insect stings or plants? (circle one).....Yes No
If yes, please explain:

Is there a history of, or any other medical condition(s) that we should know about? (circle one)Yes No
If yes, please explain:

PART 3. AUTHORIZATION FOR MEDICAL CARE

In cases where medical attention is necessary, but does not appear to be critical or major, the grandparent will be consulted for an appropriate plan of action (eg: scratch or cut on knee). In cases where more than a First Aid response appears to be appropriate, parents will be contacted for approval when possible. However, we are required to have on file a medical release form signed by the parent.

_____ (Child's Name) has my permission to receive medical attention in the event of illness or medical emergency while participating in this Auburn University Intergenerational Elderhostel program. I will assume the financial responsibility for any cost of health care for my child that may occur during this Intergenerational Elderhostel program.

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

By revealing or disclosing the above medical information it will not be used by Auburn University personnel or employees to determine my child's ability to participate safely in activities. I understand that, if my child chooses to participate in activities, he/she does so voluntarily and of his/her own accord.

SIGNATURE IS REQUIRED:

Parent/Legal Guardian's Name _____

Parent/Legal Guardian's Signature _____

Date _____

PART 4. PARENT/GUARDIAN AUTHORIZATION FOR MEDICATION

_____ My child does not need to take any prescription medication while at Intergenerational Elderhostel.

_____ My child will need to take prescription medication while at Intergenerational Elderhostel.

_____ **I authorize the attending grandparent to administer prescription medication.**

- 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 grandchild will be attending the Intergenerational Elderhostel.
- *All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to the Intergenerational Elderhostel under the condition that the attending grandparent can manage care and delivery of medication.*

IMPORTANT INFORMATION ABOUT CHILD'S 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: _____

Relevant side effects: _____

Special Storage Requirements: _____

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

Prescriber's Telephone: _____ Prescriber's Fax: _____

PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

I authorize the attending grandparent to administer prescription medications. I also affirm that the attending grandparent has been instructed in the proper administration of the prescribed medication. I shall indemnify and hold harmless the Intergenerational Elderhostel Staff, Auburn University, 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 administered prescribed medication(s).

I/We have legal authority to consent to medical treatment for the grandchild named above, including the administration of medication at the above referenced Intergenerational Elderhostel.

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR OVER-THE-COUNTER MEDICATION

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the grandchild'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 _____ (Child's Name) 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.
- Aspirin/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) _____

Intergenerational Elderhostel 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 be not 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 did not respond to the above outlined treatment, would be followed-up with a consultation with the child's grandparents, and also parents, if needed. Grandparent/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. If you foresee the need for one of these OTC medications, then please pack accordingly.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless the Intergenerational Elderhostel Staff, Auburn University, 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 grandchild named above, including the administration of medication at the above referenced Intergenerational Elderhostel.

Parent/Guardian Signature: _____ Date: _____