Youth Program Medical Information and Release Form

Program Information

Program Name: _____

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

Location: _____

This information will be kept in strict confidence and will only be shared with your permission. Auburn University requests the information below so that, in case of emergency, we will have accurate information to provide and/or seek appropriate treatment for Participant. You are accountable for providing an accurate medical history.

As the parent or legal guardian of the minor child named below ("Participant"), 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. **Final determination about whether to participate is the responsibility of the parent/guardian and Participant's physician.**

General Information

Participant Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Emergency Contact #1: _____ Relationship to Participant: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Emergency Contact #2: _____ Relationship to Participant: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Medical Information

It is recommended that Participant 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.***

Although immunizations are not required for participation, we strongly encourage that program participants are appropriately immunized for, at minimum, the following diseases: tetanus, measles, mumps, rubella (MMR), meningococcal meningitis.

Date of most recent tetanus toxoid immunization, if known: _____

Please read and initial the statements below:

☐ I understand and acknowledge that because immunizations are not required, program participants may be exposed to individuals who have not been immunized and/or individuals who may carry infectious diseases, which may result in Participant contracting an infectious disease.

☐ I understand and accept the risks to Participant that relate to and arise from potential exposure to and contraction of an infectious disease.

☐ **I understand that Auburn University does not offer any form of insurance for Participant while participating in the Program.**

For the following questions, indicate the response and explain as appropriate. Use additional pages if needed.

Does Participant have any limiting medical conditions that you or your doctor feel would limit participation in the program?

◯ YES ◯ NO If yes, identify and explain:

Is Participant currently taking medication that may interfere with their ability to safely participate in the program?

◯ YES ◯ NO If yes, identify and explain:

Does Participant have a history of allergies or reactions to medications, latex, insect stings, plants, etc.?

◯ YES ◯ NO If yes, identify and explain:

Does participant currently have or have a history of medical condition(s) of which we need to be aware?

◯ YES ◯ NO If yes, identify and explain:

Will your child need to take medication(s) during the program?

◯ YES ◯ NO If yes, see below.

If yes, please complete a Medication Management Form for each medication, place the completed form(s) with the medication(s) in a zip- top bag clearly labeled with Participant's name and date of birth, and provide the bag to a program staff member at check-in. Please consult with the Program Director if Participant has emergency medication(s) that must stay with them at all times.

Disability Information

Does your child have a disability that requires accommodations to enable them to participate in the Program?

◯ YES ◯ NO

To request accommodations, contact the Program Director, who will coordinate with the Office of Accessibility. Requests should be submitted in writing at least 30 days prior to the event. Late requests may not be accommodated due to time constraints.

If accommodations are requested, I give Auburn University permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include sharing information with appropriate University personnel, and I acknowledge that such communication is consistent with business necessity. **Please initial**

Food Allergy/Intolerance or Other Dietary Concerns

Does your child have a food allergy, food intolerance, or other dietary concern?

◯ YES ◯ NO If yes, identify and explain:

If yes, please complete the Food Allergy, Intolerance, or Dietary Concern Form.

Other 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.

Medical Care

In cases where medical attention is necessary, parents/guardians 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.

Authorization for Medical Care

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

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

I understand that by revealing or disclosing the above medical information it will not be used by Auburn University personnel or employees to determine Participant's ability to participate safely in activities. I understand that if Participant chooses to participate in activities, they do so voluntarily and of their own accord and the final decision regarding participation is solely the responsibility of myself and Participant.

I hereby hold harmless and agree to indemnify the Youth Program, Youth Program Personnel, Auburn University; its Board of Trustees, individually and collectively; Administrators; Faculty; Staff; and all other officers, directors, employees, and agents against any claims that may arise relating to Participant's medical care while participating in this Program.

Participant Name: _____

Participant Signature: _____ **Date:** _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

A PARENT OR LEGAL GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 19