

**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 or does not] 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 (if applicable) 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:

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Does participant have a history of allergies or reactions to medications, insect stings, or plants?  YES  
 NO

If yes, please explain:

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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:

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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 \_\_\_\_\_