Youth Programs – Protection of Non-Student Minors

Medical Information Form and Authorization for Medical Care

Basic Personal Information (please print): ____ Today's Date: ______/______/______

Child's Name: ____ Age: ____________________

Local Address: ____

City: ____ State: ________________________ Zip Code: __________

Cell Phone Number: ________________________ Work Phone Number: _______________ Home Phone : ____________

Height: ____ Weight: __________________________

Emergency Contact Information

Person to notify in case of emergency: ____ Relationship: ___________

Primary Contact's Phone Number(s): (____) _____________________________________, (_____) _________________________________

Contact's Address: ____

City: _______________________________ State: _______________________ Zip Code: __________

Secondary Contact's Name: ____

Phone Number: (_____)_______________, (_____)_________________, (_____)__________________

Family Physician: ___________________________________ Phone number: (_____) ______________

Insurance Provider: ____Phone Number (_____) ______________

Policy Number: ____

(Note: The institution does not offer any form of health, liability, or other types of insurance for participants. Please attach a copy of the front and back of your insurance card with this form.)

Medical Information

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

List any allergies your child has (medications, insect bites/stings, food, iodine, latex, etc.
____

List any medications your child is currently taking, their purpose, dosage, and times taken:
____

Does your child need any accommodation to safely participate in the program? If yes, please explain.
____

Does your child require any assistance with his or her medications? If so, please explain.
____

Authorization for Medical Care I understand that my child is voluntarily participating in an Albany State University Program. 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 the program. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program. I agree to notify the program of any changes in my child's mental, physical or medical condition before the program begins.

I understand that Albany State University does NOT provide medical insurance for my child and that I should consult my child's physician before allowing my child to participate in this program. In the case of accident or illness, I hereby authorize the program staff to administer or seek medical treatment for my child, as they see fit, including routine first aid care or emergency medical treatment. I hold harmless and agree to indemnify the program, Albany State University, and the Board of Regents from any claims, causes of action, damages, and/or liabilities arising out of or result 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.

Name of Participant: ____ Date: _____/_____/_____

Signature of Parent or Guardian: ____

Parent of Guardian Name (printed): ____

Work Phone: _________________________________ Cell Phone: _____________________________

Routing: Retain for event file.