Dickinson College Programs Serving
Minors - Medical Information and Release Form

PROGRAM/CAMP INFORMATION:
Program/Camp Name:
Date(s):
Location:

PARTICIPANT INFORMATION:
Name of Participant:
Date of Birth:
Phone Number:
Address:
City: State: Zip:

As a minor, parent or guardian 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. This information will be kept in strict confidence and will only be shared with your permission. Dickinson College requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment for Participant. You are accountable for providing an accurate medical history. Final determination about whether to participate is the responsibility of you and your physician. 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.

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.

I understand that Dickinson College does not offer any form of insurance for Participant while participating in Program.

PART 1. GENERAL INFORMATION:
Parent/Legal Guardian's Name (if applicable)
Street Address

City: State: Zip:
Home Phone: Cell Phone: Work Phone:

Please list two emergency contacts other than Parent/Legal Guardian:

Emergency Contact#1:
Name Relation:
Home Phone # Work Phone # Cell Phone #

Emergency Contact#2:
Name Relation:
Home Phone # Work Phone # Cell Phone #

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 #:

PLEASE ENCLOSE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD WITH THIS FORM

For the following, circle appropriate response and explain as appropriate:

A. Does Participant have any limiting medical conditions that you or your doctor feel would limit participation? YES NO

If yes, identify and explain:

B. 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:

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

If yes, please explain:

D. 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:

PART 3: AUTHORIZATION FOR MEDICAL CARE:

Unless prior arrangements have been made, medical needs will be handled through the UPMC Pinnacle Carlisle Hospital, or another available and convenient entity. In cases where medical attention is necessary, parents 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. The hospital will not perform services unless this form is presented at the time of treatment. Participant has my permission to receive medical attention in the event of illness or medical emergency while participating in this Program. I will assume the financial responsibility for any cost of health care for my child that may occur during this Program. 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 Dickinson College pertaining to my Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify Dickinson College of any changes in my mental, physical or medical condition prior Participant's scheduled Program. By revealing or disclosing the above medical information it will not be used by Dickinson College personnel or employees to determine Participant's ability to participate safely in activities. I 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 myself and Participant.

Participant Name: Participant Signature:
Date:

Parent/Guardian's Name: Parent/Guardian's Signature:
Date:

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 18

Dickinson College Programs Serving Minors Parent/Guardian Authorization, Waiver and Consent for Self- Administration of Prescription Medication Form

PROGRAM/CAMP INFORMATION:
Program/Camp Name: Date(s):
Location:

PARTICIPANT INFORMATION:
Name of Participant: Date of Birth:
Phone Number:
Address: City: State: Zip:
Parent/Legal Guardian
Home Phone Cell Phone
Parent/Legal Guardian address (if different from above)

This form must be completed fully in order for Participants to self-administer required medication. A new medication administration form must be completed for each Program attended by the Participant, for each medication, and each time there is a change in dosage or time of administration of a medication. Self- medication requires licensed health care authorization and signature, and parent signature.

Circle One: No, my child does not need to take any prescription or over-the-counter medication while at the Program. Yes, my child will need to take prescription medication while at the Program.

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 the Participant can self-manage care and delivery of medication with written authorization to do so at camp by a licensed health care provider. 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 participant will be attending the Program.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION:

Medication Name:
Dose:
Condition for which medication is being administered:

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's Name:

Parent/Guardian's Signature: Date: