University of Cincinnati
AUTHORIZATION TO PROVIDE MEDICAL TREATMENT TO A MINOR

Name of Program:

As a student, 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.*** The University of Cincinnati 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 the University of Cincinnati does not offer any form of insurance for participant while participating in Program.

PART 1. GENERAL INFORMATION

Participant Name _____ KUHDIWHBU:WLFLSDQW´

Parent/Legal Guardian Name (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Home 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? 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:
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:

Does participant have a history of allergies or reactions to medications, insect stings, or plants?
Yes **No**

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

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.

I give permission to the staff to arrange necessary related transportation for the Participant. In the event I cannot be reached in an emergency, I hereby give permission to the physician and dentist named above to administer treatment, including hospitalization at _____ (named hospital) or any hospital reasonably accessible, for the Participant named below.

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 the University of Cincinnati pertaining to my Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify the University 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 University of Cincinnati 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 do 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 Name_____

Parent/Guardian Signature_____ Date:

THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR GUARDIAN BEFORE A MINOR CAN PARTICIPATE IN THE PROGRAM.

The completed form is to be retained by the administrative office responsible for the potentially hazardous non-laboratory area. Send a copy of the completed and signed form to Environmental Health & Safety, ML 0218.