JAMES MADISON UNIVERSITY

Youth Programs Medical Authorization Form

Minor Participant Full Legal Name (first, middle, last): _____

Minor Participant Date of Birth (MM/DD/YY): _____

Program Name: _____

DIETARY RESTRICTIONS/ALLERGIES

Please list all dietary restrictions and allergies (medication, food, bee stings, poison ivy, etc.) and describe the nature of the reaction (rash, hives, difficulty breathing, etc.).

PHYSICAL/MEDICAL/MENTAL CONDITIONS

Please list all physical/medical/mental conditions (asthma, diabetes, cardiac disorders, seizure disorders, ADHD, anxiety, history of heat illness or cramping, etc.).

PRESCRIPTION MEDICATIONS NEEDED WHILE AT THE PROGRAM (*Non-lifesaving medications are not allowed on site for non-residential programs). Please provide additional information requested in PART A and PART B below.*

Please list all lifesaving current prescription medications needed at the program (Inhaler, Epi-pen, Insulin etc).

PHYSICIAN INFORMATION

Please list the name and contact information of the minor participant's physician (phone number, physical address).

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INSURANCE INFORMATION

Instructions: ***Medical insurance is not a requirement of the program.*** *If minor participant does not have medical insurance, check here.* ☐

If the minor participant does have medical insurance, please provide the below information, or attach a copy of the front and back of the minor participant's insurance card.

Health Insurance Company: _____

Policy Number: _____ Group Number: _____

Effective Date: _____ Termination/Renewal Date: _____

Type: ☐ 1) POS ☐ 2) PPO ☐ 3) HMO ☐ 4) MEDICAID ☐ 5) MILITARY ☐ 6) INTERNATIONAL

Insurance number to call to confirm benefits: _____

Please list any additional medical coverage: _____

Please fill out the below information for the Insurance **Policy Holder.**

Name & Relationship: _____Date of Birth: _____

Address: _____City, State & Zip: _____

Phone: _____Email: _____

☐ Check here if your personal health insurance policy is an out-of-state Medicaid policy (not from Virginia).

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COMMUNICABLE DISEASE DISCLAIMER

I understand that although James Madison University holds the health and safety of its community as paramount, there is no guarantee that my minor participant will not be exposed to or infected with a communicable disease during participation in this program or associated activities. I understand that, if I choose to allow my minor participant to participate, the physical presence of my minor participant as well as participation and utilization of facilities, services, and programs at James Madison University may carry heightened risks that cannot be eliminated regardless of the care and reasonable efforts taken to avoid and mitigate those risks. Despite these risks, I chose to have my minor participant participate in the camp, program, and associated activities. I have read and fully understand the risks associated with participation and I voluntarily and knowingly assume those risks for my minor participant as a condition of participation.

MEDICATION & AUTHORIZATION

I understand, acknowledge, and agree:

- in accordance with the Youth Program procedure, non-lifesaving medication(s) should be given at home before and/or after the Youth Program and that non-lifesaving medications are not allowed at non-residential programs.
- to disclose the intention to bring lifesaving medications to the Program (i.e., inhalers, EPI-pens, insulin injections). Before the start of the Program or upon arrival to the Program, parent(s)/legal guardian(s) should plan to meet with a member of the Program staff at registration to review medication needs for their minor participant and complete additional required paperwork if not completed prior to arrival.
- For residential programs only- Youth Program staff will not dispense non-lifesaving medications but may monitor the self-administration of certain medications, if necessary, ONLY upon written consent of the parent(s)/legal guardian(s) and/or physician's orders.
- that all medications must be stored in the original product packaging and clearly labeled with the minor participant's name and the medication's name and dosage instructions, as well as the prescribing physician's name and telephone number.
- the need for emergency medication may require that a minor participant carry the medication on their person or that it be easily accessed (i.e., inhalers, EPI-pens, insulin injections). Program staff or other staff or volunteers affiliated with the Program will NOT purchase medications of any type (prescription or over-the-counter) for minor participants of any age.
- it is NOT permissible for my minor participant to share any medications with any other participants or with staff.
- it is the responsibility of the parent(s)/legal guardian(s) to be sure that their minor participant's medications brought to the Program are not left behind at the end of the Program. Failure to do so will result in the medications being destroyed within three working days after the minor participant's last day at the Program. Absolutely no medications will be returned via mail regardless of the circumstance.

MEDICAL CARE

- I understand, acknowledge, and agree that James Madison University does not provide medical care or medical insurance to cover emergency care or medical treatment of my minor participant.
- I give permission to the Program Staff to give basic first aid treatment (excluding non-life saving medications) to my minor participant if they become hurt/injured during the Program activities.
- I agree to the release of medical records necessary for treatment to the appropriate medical care provider.
- James Madison University is committed to protecting the medical and related health information about your minor participant. Information will be stored, archived, and disposed of according to the University record retention policies.
- If there is insufficient time to contact me, or the individuals designated on my minor participant's registration form, I give permission to the leaders of this program to secure emergency medical treatment for my minor participant, and to secure routine, non-surgical medical care as needed from licensed health care practitioners acting within the scope of their practice under State law, to provide medical care that includes routine diagnostic procedures (e.g., x-rays, blood, and urine tests) and medical treatment as necessary to my minor participant.
- Parents/guardians must be reachable in the event of an emergency. Parents/guardians shall be notified immediately of any serious illness or injury to the minor participant. If the parent/guardian cannot be reached, program staff will contact those listed on the minor participant's emergency contact form. If parents/guardians or emergency contacts cannot be reached or do not arrive to the program site by the time a minor participant must be transported by ambulance to a hospital, a program staff member will accompany the minor participant to the hospital.

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SIGNATURE

I have read and completed this Medical Authorization Form prior to signing below, and I fully understand the contents, meaning, and legal impact of this consent and release. I understand that I am free to address any specific questions regarding this consent and release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this consent and release. I agree that this Medical Authorization Agreement shall remain in effect for the duration of the Program. All participants must have a new Medical Authorization Form completed each year.

_____

Parent/Legal Guardian's Name (Please Print)

_____

Parent/Legal Guardian's Signature Date

Part A: Lifesaving Medications (ex. Epi-pen, Inhaler, Insulin etc.)

Program staff has my permission to administer the following medication in the event of an emergency.

Medication Name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____

(Program Start Date) (Program End Date)

Part B: Non-Lifesaving Medications *(For residential programs only.)*

My minor participant has my permission to self-administer the following medication.

Medication Name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____

(Program Start Date) (Program End Date)

Appendix A

Daily Medication Log for Residential Program Minor Participant*

Minor Participant's Name: _____ D.O.B_____

Program Name: _____

DATE	MEDICATION	DOSE	TIME	OBSERVED BY	Adverse Reactions/ Medication Errors

_____

Parent/Legal Guardian's Signature Date

**This form is for residential programs only. Parent/guardians should complete the date, medication, and dose columns prior to the residential program. The remaining columns will be completed by program staff.*

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