CHILDREN ON CAMPUS

MEDICAL AUTHORIZATION TO TREAT

UNIVERSITY SPONSORED PROGRAMS

The University of Michigan requests this information so that the Program staff can properly plan to meet the needs of each participant and, in case of emergency, that we have accurate information to provide and/or seek appropriate treatment for Participant. You are responsible for providing accurate and complete information.

All Participants must have up-to-date immunizations in order to participate in any university-sponsored program.

Program/Camp Name: ______________________ (hereafter "Program")

Date(s): ______________________

Location: ______________________

GENERAL INFORMATION

Participant Name ______________________ (hereafter "Participant")

Street Address ______________ City ______________ State ______ Zip ______

Home Phone ______________________

Date of Birth ____ / ____ / ____ Gender Male Female

INSURANCE INFORMATION

Do you have health/accident insurance? YES NO

If yes,

Company Name / Address ______________________

Policy # ______________________

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

The University of Michigan does not offer any form of health, liability or other types of insurance for the participant while participating in the Program.

MEDICAL INFORMATION

It is recommended that you consult with your child's physician before allowing your child to participate in this Program. 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 _______________

Physician's Address _______________

Date of most recent tetanus toxoid immunization (DTaP, TD) _______________

For the following, provide response and explain as appropriate:

Does participant have any limiting medical conditions that you or your doctor feel may limit Program 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, identify and explain: _______________

Is the participant taking any medications that must be administered during the Program? YES NO

If yes, identify and explain: _______________

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

If yes, identify and explain: _______________

Does participant have a history of, or currently suffer from, medical condition(s) about which we need to be aware? YES NO

If yes, identify and explain: _______________

Does the participant need any accommodations to safely participate in the Program? YES NO

If yes, identify and explain: _______________

If Participant has any other medical condition or special needs that you think is important for Program staff to know about, please include that information here.

Other Information: _______________

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AUTHORIZATION FOR MEDICAL CARE

To the best of my knowledge, my child/participant is capable of participating safely in the Program and that any activity restrictions, allergies, medications are listed on this form.

I give permission to Program staff to provide routine first aid care and in the event of serious illness or injury, I give Program staff permission to seek and authorize emergency medical treatment. I hold harmless and agree to indemnify the Program and the University of Michigan from any claims, causes of action, damages and/or liabilities arising out of or resulting from said medical treatment. I further agree to accept full responsibility for any and all expenses, including medical expenses, that may derive from any injuries to my child that may occur during his/her participation in this Program.

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 that I have provided all materials and important information to the Program pertaining to Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify the Program of any changes in my mental, physical or medical condition before the Program begins.

Parent/Legal Guardian Name: ______________________________

Signature: ______________________________

Work Phone: ______________ Cell Phone: ______________

Date ______________________________

Parent/Legal Guardian Name: ______________________________

Signature: ______________________________

Work Phone: ______________ Cell Phone: ______________

Date ______________________________

EMERGENCY CONTACT INFORMATION

List at least two and up to four individuals who may be contacted in case of emergency involving your child. Each person listed should be reachable by telephone and able to make decisions on behalf of your child if a parent and legal guardian cannot be reached. If necessary, an emergency contact should be able to come to the Program site and pick up your child.

Emergency Contact #1 Name ____________________

Home Phone # ____________________ Work Phone # ____________________

Cell Phone # ____________________ Relation ____________________

Emergency Contact #2 Name ____________________

Home Phone # ____________________ Work Phone # ____________________

Cell Phone # ____________________ Relation ____________________

Emergency Contact #3 Name ____________________

Home Phone # ____________________ Work Phone # ____________________

Cell Phone # ____________________ Relation ____________________

Emergency Contact #4 Name ____________________

Home Phone # ____________________ Work Phone # ____________________

Cell Phone # ____________________ Relation ____________________