CHILDREN ON CAMPUS
UNIVERSITY OF MICHIGAN

MEDICAL HISTORY AND TREATMENT AUTHORIZATION

Name _____ Sex _____ Birth Date _____

Mailing Address _____ City _____ Zip_____

HEALTH HISTORY

Has the participant ever been diagnosed with asthma or exercise-induced asthma?	Yes ☐	No ☐
Has the participant ever been dizzy, passed out, had chest pain, complained of being tired out more quickly than their friends, had trouble breathing or cough during or after exercise?	Yes ☐	No ☐
Has the participant ever been told he/she has a heart murmur, racing heart, or skipped heartbeats?	Yes ☐	No ☐
Has the participant had any injuries of any bones/joints (head, chest, shoulder, elbow, wrist, hip, knee, ankle, neck, back, etc.) or skin problems (itching, rashes, acne, etc.) during the past 12 months?	Yes ☐	No ☐
Has the participant been hospitalized or had surgery during the last 12 months?	Yes ☐	No ☐
Does the participant have allergies (foods, bees or other stinging insects)?	Yes ☐	No ☐
Has the participant been advised by a physician during the last 12 months not to participate in physical activities?	Yes ☐	No ☐
Has the participant ever been diagnosed with a seizure disorder?	Yes ☐	No ☐
Has the participant had a head injury, been knocked unconscious or been diagnosed with a concussion during the last three years?	Yes ☐	No ☐
Does the participant currently take any medications? If so, please list the reason, medication and dosage?	Yes ☐	No ☐
Has the participant ever had a reaction to medications? If so, please list the medication and describe the reaction?	Yes ☐	No ☐
Does the participant have a history of, or currently suffer from, medical conditions(s) that you or your doctor feel may limit participation or about which we need to be aware?	Yes ☐	No ☐

If you answered yes to any of the above questions, please identify and explain:

_____

_____

PRESCRIPTION MEDICATIONS

_____

_____

OVER-THE-COUNTER MEDICATIONS

Select Over-the-Counter (OTC) medication may be administered if we have permission from the child/participant's parent/guardian. **Unless we have parental authorization, we will not administer ANY medications or make OTC medications available to participants unless necessary as part of general first-aid treatment.**

I give permission for the Program/Event staff to administer the following medications to my child/participant consistent with medication directions, if the need arises. Check all that apply.

- ☐ Antihistamines (hives, swelling, allergic reaction, etc.)
- ☐ Bug Repellant
- ☐ Decongestants
- ☐ Eye drops for minor eye irritation
- ☐ Gastrointestinal distress (upset stomach, heartburn, diarrhea, etc.)
- ☐ Ibuprofen
- ☐ Sunscreen
- ☐ Topical ointments or powders (sunburn, anti-fungal, itch, sting, etc.)
- ☐ Throat lozenges or spray for sore throat
- ☐ Other

☐ Do not provide any OTC that contains the following:

_____

EMERGENCY CONTACTS

Emergency Contact #1 Name	Home Phone #	Work Phone #	Cell Phone #	Relation
Emergency Contact #2 Name	Home Phone #	Work Phone #	Cell Phone #	Relation

AUTHORIZATION FOR MEDICAL CARE

To the best of my knowledge, my child/participant is capable of participating safely in the Program/Event and that any activity restrictions, allergies, and medications are listed on this form**.** 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/event. By signing my name I represent and warrant that I have provided all materials and important information to the University of Michigan pertaining to Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify the University of Michigan of any changes in my child's mental, physical or medical condition prior the scheduled program/event.

I give permission to Program/Event staff to provide routine first aid care and in the event of serious illness or injury, I give Program/Event staff permission to seek and authorize emergency medical treatment. I hold harmless and agree to indemnify the Program/Event 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/event.

By revealing or disclosing the above medical information it will not be used by University 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.

Parent/Guardian Signature _____ Date _____

MEDICAL INSURANCE (optional)

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/Event. If you have insurance, please provide the following information to be used only in the event that medical care for your child/participant is needed.

Company Name / Address

_____

Policy # _____ Group # _____