



**MEDICAL AUTHORIZATION TO TREAT**

NON-UNIVERSITY SPONSORED PROGRAMS

Program staff request this information so that we 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 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 condition or special needs that you think is important for Program staff to know about, please include that information here.

Other Information:

## **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:

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Signature:

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Work Phone:

Cell Phone:

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Date

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Parent/Legal Guardian Name:

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Signature:

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Work Phone:

Cell Phone:

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Date

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## 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

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Home Phone #

Work Phone #

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Cell Phone #

Relation

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Emergency Contact #2 Name

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Home Phone #

Work Phone #

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Cell Phone #

Relation

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Emergency Contact #3 Name

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Home Phone #

Work Phone #

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Cell Phone #

Relation

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Emergency Contact #4 Name

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Home Phone #

Work Phone #

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Cell Phone #

Relation

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