UNIVERSITY *of* **INDIANAPOLIS**

This Document Applies to All University Programs Involving Minors

Medical Authorization to Treat

University of Indianapolis requests the following information so that the Program staff can arrange for medical care in the event of an emergency. You are responsible for providing accurate and complete information.

Program/Camp Name: ____
Date(s):______________________ Location:__________________________

GENERAL INFORMATION

Participant Name: ____
Street Address: ____
City: _______________ State: ___________ Zip Code: ________
Home Phone: ____________________ Cell Phone: _______________
Date of Birth: ___________________
Gender: __Male __Female __Other

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary): ____

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In the event of an emergency the below information will be provided to emergency first responders: Allergies - Include medication, food and others (insect stings, asthma, animal dander etc.) Describe reaction and management of the reaction.

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Does your child carry an Epi-Pen? ____________

Medications: Please list ALL medication taken routinely. Keep medication in the original packaging/bottle that identifies the prescribing physician (if prescription), the name of the medication, the dosage, and the frequency of administration.

Med: _______________ Dosage___________ Times of day taken__________________
Med: _______________ Dosage___________ Times of day taken__________________
Med: _______________ Dosage___________ Times of day taken__________________
Med: _______________ Dosage___________ Times of day taken__________________
(Attach additional pages for more medications)

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: ____________________

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, and medications are listed on this form.

I give my 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 agree to indemnify and hold harmless the University of Indianapolis, and it's officers, employees and agents, from any claim, damage, liability, injury, expense, or loss, including defense costs and attorney's fees, 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 mental, physical or medical condition before the Program begins.

Parent/Legal Guardian Name: ______________________________

Signature: ______________________________

Work Phone: ____________________ Cell Phone: ____________________

Date: ____________________ E-mail: ____________________