Initial

UNIVERSITY OF CINCINNATI
Camp Information and Release Packet

PROGRAM/ACTIVITY/CAMP INFORMATION

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

Date(s): _____ **Time(s):** _____

Location: _____

As a student, parent or guardian I understand that the information requested on this form is intended to help inform program staff of any pre-existing medical conditions. If Participant has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. ***This information will be kept in strict confidence and will only be shared with your permission.*** The University of Cincinnati requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment for Participant. You are accountable for providing an accurate medical history. **Final determination about whether to participate is the responsibility of you and your physician.** If Participant has any medical issue that is not requested below, but which you think is important, please include that information. It is recommended that you consult with a physician prior to participating in this Program. If you are uncertain about any preexisting medical conditions, it is your responsibility to consult with your own physician prior to participating in this Program. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated. Use back and/or additional paper if needed.

I understand that the University of Cincinnati does not offer any form of insurance for participant while participating in Program.

UNIVERSITY OF CINCINNATI
Youth Program/Activity/Camp Medical Information and Release Form

PART 1. GENERAL INFORMATION

Participant Name _____ (hereafter "Participant")

Parent/Legal Guardian Name (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth ____/____/____ Gender M ☐ F ☐

Please list two emergency contacts:

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

PART 2. MEDICAL INFORMATION

It is recommended that Participant consult with your physician prior to participating in this Program. If you are uncertain about any preexisting medical conditions, ***it is your responsibility to consult with your own physician*** prior to participating in this Program. Please answer all of the questions. 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 _____

Date of most recent tetanus toxoid immunization _____

Do you have health/accident insurance? ◯ YES ◯ NO

If yes, please indicate policy number, name and address of insurance company.

Initial

Company Name / Address _____ Policy # _____

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

For the following, circle appropriate response and explain as appropriate:

Does participant have any limiting medical conditions that you or your doctor feel would limit camp 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, please indicate the medication and the condition being treated:

Does participant have a history of allergies or reactions to medications, insect stings, or plants? ☐ **Yes** ☐ **No**

Does participant have a history of, or currently suffer from, medical condition(s) with which we need to be aware? ☐ **Yes** ☐ **No**
If yes, please explain:

PART 3: AUTHORIZATION FOR MEDICAL CARE

In cases where medical attention is necessary, parents will be contacted for approval when possible. However, before medical treatment can be provided, we are required to have a medical release signed by the parent/guardian. The hospital will not perform services unless this form is presented at the time of treatment.

I give permission to the staff to arrange necessary related transportation for the Participant. In the event I cannot be reached in an emergency, I hereby give permission to the on-site medical staff named above to administer treatment, including hospitalization at _____ (named hospital) or any hospital reasonably accessible, for the Participant named below.

Participant has my permission to receive medical attention in the event of illness or medical emergency while participating in this Program. I will assume the financial responsibility for any cost of health care for my child that may occur during this Program.

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. By signing my name, I represent and warrant that I have provided all materials and important information to the University of Cincinnati pertaining to my Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify the University of any changes in my mental, physical or medical condition prior Participant's scheduled Program.

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

Participant Signature

Parent/Guardian Signature

Date

Date

Initial

UNIVERSITY OF CINCINNATI

Guardian Authorization, Waiver and Consent for Self-Administration of Prescription Medication Form

This form must be completed fully in order for participants to self-administer required medication. A new medication administration form must be completed for each Program attended by the participant, for each medication, and each time there is a change in dosage or time of administration of a medication. Self-medication requires licensed health care authorization and signature, *and* parent signature.

☐ **No, my child does not need to take any prescription medication while at the Program.**

☐ **Yes, my child will need to take prescription medication while at the Program.**

If checked no, please disregard bottom portion:

All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so at camp by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the participant will be attending the Program.

Time/Frequency of administration:_____

If PRN, frequency:_____

If PRN, for what symptoms:_____

Relevant side effects:_____

Medication shall be administered from (date_____to _____

Special Storage Requirements:_____

Is the participant capable of self-managed care? ◯ YES ◯ NO

Prescriber's Name/Title: _____

Prescriber's Place of Employment: _____ Telephone: _____

Fax: _____

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medication(s).

Parent's Signature: _____ **Date:**_____

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the Program Staff, University of Cincinnati, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child's self-administration of prescribed medication(s). ***I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced Program.***

UNIVERSITY OF CINCINNATI

Informed Consent, Voluntary Waiver, Release of Liability & Assumption of Risks Form

PROGRAM/ACTIVITY/CAMP INFORMATION

Program/Activity/Camp Name _____

Date(s): _____

Time(s): _____ **Location:** _____

PARTICIPANT INFORMATION

Name of Participant: _____

Address: _____ **City:** _____ **State:** _____

Zip: _____ **Phone Number:** _____ **Date of Birth:** _____ **Gender:**_____

PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING. THIS IS A LEGALLY BINDING DOCUMENT. THIS FULLY SIGNED FORM MUST BE SUBMITTED BY A PARENT OR LEGAL GUARDIAN BEFORE ANY CHILD IS ALLOWED TO PARTICIPATE IN THE ABOVE REFERENCED PROGRAM/ACTIVITY/CAMP.

Initial

I, the undersigned, wish for my Child (hereafter "Child") to participate in the above referenced youth program (hereafter "Program") on the date(s) and location(s) indicated above and, in consideration for my Child's participation, I hereby agree as follows:

I acknowledge, understand and appreciate that as part of my Child's participation in the Program there are dangers, hazards and inherent risks to which my Child may be exposed, including the risk of serious physical injury, temporary or permanent disability, and death, as well as economic and property loss. I further realize that participating in the youth program may involve risks and dangers, both known and unknown, and have elected to allow my Child to take part in the Program. Therefore, I, on behalf of my Child, voluntarily accept and assume all risk of injury, loss of life or damage to property arising out of training, preparing, participating and traveling to or from the Program.

I, on behalf of my Child, hereby release the University of Cincinnati, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, the Program Staff, and all other officers, directors, employees, volunteers and agents (hereafter "University") from any and all liability as to any right of action that may accrue to my heirs or representatives for any injury to my Child or loss that my Child may suffer while training, preparing, participating and/or traveling to or from the Program/Activity/Camp. This agreement is binding on my heirs and assigns.

I, on behalf of my Child, furthermore release, indemnify and hold harmless the University from and against any and all liability, actions, debts, claims and demands of every kind whatsoever, specifically including, but not limited to, any claim for negligence or negligent acts or omissions and any present or future claim, loss or liability for injury to person or property that my Child may suffer, for which my Child may be liable to any other person, that may or does arise out of my Child's participation in the Program. I understand that the University of Cincinnati accepts no responsibility for my Child's personal property.

In the event of an accident or serious illness, I hereby authorize representatives of the University to obtain medical treatment for my Child on my behalf. I hereby hold harmless and agree to indemnify the University 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 the Program.

This RELEASE shall be governed by and construed under the laws of Ohio. I agree that any legal action or proceeding relating to this RELEASE, or arising out of any injury, death, damage or loss as a result of my Child's participation in any part of the Program, shall be brought only in the Ohio Court of Claims.

This RELEASE contains the entire agreement between the parties to this agreement and the terms of this RELEASE are contractual and not a mere recital. The information I have provided is disclosed accurately and truthfully. I have been given ample opportunity to read this document and I understand and agree to all of its terms and conditions. I understand that I am giving up substantial rights (including my right to sue), and acknowledge that I am signing this document freely and voluntarily, and intend by my signature to provide a complete and unconditional release of all liability to the greatest extent allowed by law. My signature on this document is intended to bind not only myself and my Child but also the successors, heirs, representatives, administrators, and assigns of myself and my Child.

UNIVERSITY OF CINCINNATI
Guardian Authorization, Waiver and
Consent for Over-the-Counter Medication Form

Program staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed on the following page.

I understand that such administration will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the student's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless the Program Staff. University of Cincinnati, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child being administered the above indicated over-the-counter medications. I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at the above referenced program.

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay. **Note: Unless we have parental authorization, we cannot administer <u>ANY</u> medications.**

I hereby authorize that the following medications may be given to Participant if the need arises. You may dispense only those checked.

Initial

☐ Ointments for minor wound care, first aid as directed. (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
☐ Tylenol/Acetaminophen as directed.
☐ Ibuprofen as directed.
☐ Throat lozenges and or spray as directed for sore throat.
☐ Micatin or anti-fungus treatment as directed for athlete's foot.
☐ Kaopectate or Imodium for diarrhea as directed.
☐ Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea as directed.
☐ Rolaids or Tums for acid reflux, heartburn or indigestion as directed.
☐ Benadryl for swelling, hives, allergic reaction, as directed.
☐ Actifed or Sudafed as directed for nasal congestion or allergy relief per instructions.
☐ Visine or other eye drops for minor eye irritation.
☐ Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
☐ Swimmer's ear drops as directed.
☐ Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.
☐ Medicated powder for skin irritation as directed.
☐ Robitussin or other cough syrup as directed.
☐ Calamine lotion for bug bites and poison ivy.
☐ Sunscreen
☐ Bug repellent
☐ Other (list any other approved over-the-counter drugs) _____

PHOTO & VIDEO RELEASE FORM

At various times throughout the _____, staff will be taking digital images,
(Name of Program/Activity/Camp)
photographs, and or videotapes of participants for educational, promotional, and informational purposes related to print material or the web.

I hereby grant permission to the University of Cincinnati ("University") and its representatives to take photographs, videos or recordings of my voice and to use, reproduce, and/or publish photographs, video, other digital representations, and/or audio that may pertain to me, including my image, likeness and/or voice.

I further hereby authorize the University to edit, alter, copy, exhibit, publish or distribute the images or recordings, for any lawful purpose, in any media now known or later developed, as the University deems fit.

I hereby waive any right to inspect or approve the use of the images or recordings. I also agree that by signing below I release the University and any and all of its representatives from any and all monetary obligations or payments to me or any of my authorized representatives for use of video, films, photographs, image, other digital representation and/or voice of myself.

I acknowledge that the University owns all rights to the images or recordings in any medium.

I hereby hold harmless, indemnify, release and forever discharge the University of Cincinnati and its representatives from all claims, damages, liability and causes of action arising from or related to the use of the images, recordings or materials, which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I have read the above documents and releases, and understand and agree to the terms of the document in its entirety. I have fully disclosed all of Participant's medical conditions, medications and allergies, and I will notify camp director of Amendments as needed. By signing below, I agree to all conditions and indemnifications contained within the document.

Participant Name _____

Participant Signature _____

Parent/Guardian of a Minor Name _____

Parent/Guardian of a Minor Signature _____

Date _____