CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT

TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while at the University of Wisconsin – La Crosse, it is event/camp policy to secure your consent for medication administration and for the use of medical devices. The medication or medical device must be administered by designated event/camp health staff with the exception that a limited amount of medication for life-threatening conditions may be carried by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

☐ Prescription medication(s) has been brought to event/camp. All prescription medication must be in the original medicine bottle (see picture at right) and labeled with the youth participant’s name, doctor’s name, medication name, dosage, prescription number, date prescribed, and instructions. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested on the second page of this form.

☐ Over-the-counter medications have been brought to event/camp and may be administered by camp health staff as needed. All over-the-counter medications must be labeled with the youth participant’s name, medication name, dosage, and instruction.

☐ No medication(s) has been brought to event/camp.

If your son, daughter, or ward will be under the age of 18 years while at the event/camp, it is our policy to secure your agreement to all of the following statements. By signing below:

• I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.

• I am stating that I am aware of and accept the risk inherent in the program activity.

• I attest that all information on both sides of this form is correct and up-to-date, and that I will provide any and all significant, material, or important changes to any information in this form to event/camp staff no later than check-in.

• I agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin – La Crosse, their officers, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred or required arising out of the actions of my son, daughter or ward in the course of the event/camp.

Participant Name  (Please Print)

SIGNATURE OF PARENT OR LEGAL GUARDIAN  Date

(Must complete reverse side)
Health Conditions (check)

☐ Asthma
☐ Diabetes
☐ Epilepsy
☐ Psychiatric
☐ Cognitive/Developmental
☐ Any dizziness, light-headedness or fainting associated with exercise within the past year
☐ Any unexplained, rapid or irregular heart beat within the past year
☐ A physician has sometime denied or restricted participation in sports due to a heart problem

Allergies (check & list specifics)

☐ Insect stings _______________________
☐ Foods _______________________
☐ Medications _______________________
☐ Other _______________________

Do any allergies require an EPIPEN Injection? ☐ Yes ☐ No

Is an inhaler required and carried by youth? ☐ Yes ☐ No

Date of last Tetanus booster : __________

Name of Insurance Co.: __________________________ Policy #: __________________________

Description of any limitation or restriction of event activities:

Any special accommodations regarding physical or emotional conditions that we need to be aware of regarding your child’s participation in this event/camp (include circumstances when physician should be notified)?

______________________________________________________________________________________________________________________________

Medications camper will be taking at camp:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Reason</th>
<th>Dosage (mg)</th>
<th>Times of day given</th>
<th>Prescribing Physician &amp; Phone Number</th>
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1. Does the youth experience any side effects from the medication? (i.e., mood/behavior changes, upset stomach, diarrhea) ☐ Yes ☐ No

List any special instructions or additional information regarding the medication that would be helpful to the Health Care staff:

______________________________________________________________________________________________________________________________

2. ________________________________________________________________________________________________

*** FOR EVENT/CAMP USE ONLY – TO BE COMPLETED BY HEALTH CARE STAFF AT CHECK-IN ***

1. Are there any changes in your child’s health status since the medical forms were sent in? ☐ No ☐ Yes

2. Has your child, or anyone in your family been sick or exposed to any communicable disease in the past month? ☐ No ☐ Yes

3. Does your child now have any rashes or open sores? ☐ No ☐ Yes

4. Are there any changes in your dependent’s medications? (If Yes, Staff make changes & sign) ☐ No ☐ Yes

5. Does your child have any recent injury or activity restrictions? ☐ No ☐ Yes

6. Will the custodial parent(s) or guardian be available at the numbers listed on this form during the camping session? ☐ No ☐ Yes

If NO, list the name & phone number of person(s) authorized to make decisions on their behalf if different than the emergency contact listed on the reverse side of this form:

______________________________________________________________________________________________

______________________________________________________________________________________________

Information provided by: __________________________ To: __________________________ Date: __________________________