LOYOLA UNIVERSITY NEW ORLEANS
RESIDENTIAL SUMMER CAMPS – MEDICAL INFORMATION & RELEASE

Camp/Program Name: _____ Date(s): _____

Loyola University New Orleans 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 the 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 the Participant has any medical issue that is not named below but which you think is important, please include that information.

As a Participant, 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 the 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.***

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

PART 1. GENERAL INFORMATION

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.

Participant Name_____

Parent/Legal Guardian Name_____

Street Address_____

City_____ State_____ Zip_____

Home Phone_____ Mobile Phone_____

Date of Birth_____/_____/_____ Gender_____

Please list two emergency contacts (please print):

_____	_____	_____	_____
Emergency Contact Name 1	Mobile Phone	Alternate Phone	Relation to Participant
_____	_____	_____	_____
Emergency Contact Name 2	Mobile Phone	Alternate Phone	Relation to Participant

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PART 2. MEDICAL INFORMATION

It is recommended that the Participant 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.***

Physician's Name _____ Phone Number _____

Date of most recent tetanus toxoid immunization _____/_____/_____

Does the Participant have health insurance? _____YES _____NO

Please indicate policy number, name and address of insurance company. **PLEASE ENCLOSE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD WITH THIS FORM**

Company Name / Policy # _____

Address _____

For the following, circle appropriate response and explain as appropriate:
Does the participant have any limiting medical conditions that you or your doctor feel would limit camp participation?

YES **NO** If yes, identify and explain:

Is the 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 the participant have a history of allergies or reactions to medications, insect stings, or plants?

YES **NO** If yes, please explain:

Does the participant have a history of, or currently suffer from, medical condition(s) of which we need to be aware?

YES **NO** If yes, please explain:

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Does the participant have any other medical issues that you believe we need to be aware of?

YES **NO** If yes, please explain:

PART 3: AUTHORIZATION FOR MEDICAL CARE

Medical needs, with the exception of minor first aid treatment, may be handled through local Emergency Medical Services. Program staff may administer minor first aid treatment. In cases where medical attention is necessary, the Parent or Guardian 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. Hospitals will not perform services unless this form is presented at the time of treatment.

The 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 the 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 Loyola University pertaining to the Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify Loyola University of any changes in the Participant's mental, physical or medical condition.

Loyola University will **NOT** use the medical information disclosed above to determine the Participant's ability to participate safely in activities. I understand that, if the Participant chooses to participate in activities, he/she does so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of myself and the Participant.

I have legal authority to consent to medical treatment for the Participant named above.

Participant Name _____ **Parent/Guardian Name** _____

Participant Signature _____ **Date** _____

Parent/Guardian Signature_____ **Date** _____

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PART 4: OVER-THE-COUNTER (OTC) MEDICATION

4A. Over-the-Counter (OTC) Medication may at times be administered if approval is indicated by the Participant's parent or guardian. **Note: Unless we have parental authorization, we cannot administer ANY medications. (If you do not authorize the distribution of OTC Medication, please skip to Section 4B. below.)**

OTC Medication may include items from the list below. **Please mark with an X any Over-the-Counter medications that should NOT be administered to the Program Participant.**

- ☐ 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

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

Please check one of the following options:

_____ I hereby authorize that Over-The-Counter Medications may be given to the Participant if the need arises.

_____ I hereby authorize that Over-The-Counter Medications may be given to the Participant if the need arises, **with the exception of the following (please indicate by name and also mark with an X in the list above):**

_____.

I understand that the administration of OTC Medication will not be done under the supervision of medical personnel. I understand that OTC medications are not necessarily kept on hand and available to be administered immediately.

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Any condition which is associated with fever, significant inflammation, and/or does not respond to OTC Medication may be followed-up by a consultation with the Participant's Parent/Guardian or to seek emergency medical treatment if deemed necessary by Program staff.

I authorize the administration of over-the-counter medications to the Participant as indicated above. I hereby release and discharge, indemnify and hold harmless Program staff, Loyola University, and their members, officers, agents, employees, and any other persons or entities acting on their behalf, and the successors and assigns for any and all of the aforementioned persons and entities, against any and all claims, demands, and causes of action whatsoever, whether presently known or unknown, either in law or in equity, relating to injury, disability, death or other harm, against any claims that may arise relating to the administration of over- the-counter medications to the Participant.

I have legal authority to consent to medical treatment for the Participant named above, including the administration of Over-the-Counter medication to the Participant.

Participant Name _____ **Parent/Guardian Name** _____

Participant Signature _____ **Date** _____

Parent/Guardian Signature_____ **Date** _____

4B. If you **do not** authorize the administration of Over-the-Counter medications, please sign below.

I **DO NOT** authorize the administration of Over-the-Counter medications to the Participant.

Participant Name _____ **Parent/Guardian Name** _____

Participant Signature _____ **Date** _____

Parent/Guardian Signature_____ **Date** _____

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PART 5: Self-Administration of Prescription Medication

This form must be fully completed 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.**

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.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name:_____ Dose: _____

Condition for which medication is being administered: _____

Specific Directions (e.g., on empty stomach/with water, etc.): _____

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).

Prescriber'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 hereby release and discharge, indemnify and hold harmless Program staff, Loyola University, and their members, officers, agents, employees, and any other persons or entities acting on their behalf, and the successors and assigns for any and all of the aforementioned persons and entities, against any and all claims, demands, and causes of action whatsoever, whether presently known or unknown, either in

law or in equity, relating to injury, disability, death or other harm, against any claims that may arise relating to my child's self-administration of prescribed medication(s).

I have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced Program.

Participant Name _____ Parent/Guardian Name _____

Participant Signature _____ Date _____

Parent/Guardian Signature_____ Date _____