YOUTH PROGRAM: MEDICAL INFORMATION FORM

Participant Name:_____ **Date of Birth:** _____

Program/Activity Name:_____**Program Date:**_____

Instructions

UNC Greensboro requests the information on this form to ensure that Youth Programs have accurate information in the event of an emergency. It is recommended that you consult with a physician prior to participating in this program. If the participant has a pre-existing medical condition, participation in any strenuous activity may not be recommended. You are accountable for providing an accurate medical history. Final determination about the appropriateness of participation is a determination to be made by you and the participant's physician.

Please answer all questions below. List medications or medical conditions below including all allergies. If the participant has any medical issue that is not specifically covered below, but which you think is important, please include that under Additional Information. Program staff members are not permitted to administer medications; however, they may store and provide access to medication pursuant to the Participant's Medication Management Plan. Medication may not be shared. If your participant is prone to indigestion, headaches, or menstrual cramps, please send appropriate medication and list it here. The medication will be stored with a staff member who will allow the participant to take it as indicated on the original label. Medicines must be in the original packaging.

Parent/Guardian Information

Name of Parent/Legal Guardian: _____

Address:

_____

City:_____State:_____Zip: _____

Primary Phone Number:_____Alternate Phone Number: _____

_____

Email: _____

Emergency Contact Information

Primary Person to notify in case of emergency:_____

Relationship:_____

Contact's Phone Number(s):_____

Secondary Person to notify in case of emergency:_____

Relationship: _____

_____

Contact's Phone Number(s):_____

Participant's Physician:_____Phone Number: _____

Insurance Information

I am covered by hospital insurance: ____Yes_____No

Name of Insurance Company: _____

Policy or Certificate Number: _____

Insurance subscriber name:_____Subscriber date of birth: _____

Name of Doctor:_____ Phone Number: _____

(Please attach a copy of the front and back of your insurance card with this form.)

I understand that The University of North Carolina at Greensboro does not offer any form of health, liability, or other insurance coverage for participants. (Please initial:_____)

Immunizations

Although UNCG does not require immunizations for participation, we strongly encourage that program participants are appropriately immunized for, at minimum, the following diseases:

- Tetanus
- Measles
- Mumps
- Rubella (MMR)
- Meningococcal meningitis

By signing below, I acknowledge and accept the following:

Because immunizations are not required, program participants may be exposed to individuals who have not been immunized and/or individuals who may carry infectious diseases, which may result in a program participant contracting an infectious disease. I understand and accept the risks to my child that relate to and arise from potential exposure to and contraction of an infectious disease**.** I further understand that guests in UNCG facilities, including youth program participants, are subject to the UNCG Communicable Disease policy. Pursuant to that policy, management of public health incidents at UNCG, including isolating the infected person(s) and/or quarantining their contacts or testing their contacts, shall occur at the direction of the North Carolina and/or Guilford County Departments of Health & Human Services.

Signature of Parent/Guardian:_____ Date:_____

Medical Concerns

Please list any current medical concerns or medical history we need to know about your child: (Ex. past injuries, current conditions, physical limitations, etc.)

List any allergies: (Ex. medications, bee stings, food, latex, plants, etc.)

List any dietary restrictions:

Participant Name:_____ Date of Birth: _____

Will your child need to take medication(s) during the program? ___Yes ___No

Please complete a Medication Management Form for each medication, place the completed form(s) with the medication(s) in a zip- top bag clearly labeled with the participant's name and date of birth, and provide the bag to a program staff member at check-in. These medications will be secured and provided to the child as described in the Medication Management Form. Please consult with the program director if your child has medication(s) that must stay with them at all times.

Does your child have a disability that requires reasonable accommodations to enable them to participate in the program/activity?

_____Yes_____No

To request reasonable accommodations, [INSERT PROGRAM DIRECTOR's CONTACT INFORMATION]. Requests should be submitted in writing at least 30 days prior to the event. Late requests may not be accommodated due to time constraints.

If accommodations are requested, I give the UNC Greensboro permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include sharing information with appropriate University personnel, and I acknowledge that such communication is consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. (**Please initial:** _____)

Additional Information

Please provide any additional information or explanation that you feel could be relevant or beneficial for our staff to know in supporting your child during this program. (Attach additional information, if necessary.)

Authorization for Medical Care

I understand that my child is voluntarily participating in a program at UNC Greensboro. By signing this form, I hereby acknowledge that all information is accurate and current, and, to the best of my knowledge, my child is capable of participating safely in this program. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program. I agree to notify the program/activity of any changes in my child's mental, physical, or medical

condition before the program begins.

In the case of accident or illness, I hereby authorize the program/activity staff to administer or seek medical treatment for my child, as they see fit, including routine first aid care or emergency medical treatment. However, I understand and acknowledge that such staff are not medical professionals. I hold harmless and agree to indemnify the program, UNC Greensboro and its agents and employees, from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment or lack thereof. I acknowledge that I am solely responsible for any hospital or other costs arising out of any illness, bodily injury or property damage sustained through my child's participation in such voluntary program.

Signature of Parent/Guardian:_____ Date: _____

Parent/Guardian Name:_____