The University of Texas Rio Grande Valley

SUMMER CAMP APPLICANT AND CONFIDENTIAL MEDICAL INFORMATION

Camp Name: Coastal Studies Lab: MARINE SCIENCE SUMMER YOUTH DAY CAMP

Date(s): JUNE 13-14, 20-21 JULY 11-12, 18-19, 25-26 Preferred Date: _____

Time(s): 8 AM - 2 PM Please circle, enter, or highlight date.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLLY.
AS A CAMPER, PARENT OR GUARDIAN I UNDERSTAND THAT: The information requested on this form is intended to help inform staff of any pre-existing medical conditions. If your child has a pre-existing medical condition, participation in any strenuous or recreational time may not be recommended. ***This information will be kept in strict confidence and will only be shared with your permission.*** UTRGV 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. You are accountable for providing an accurate medical history. ***Final determination about whether to participate is the responsibility of you and your physician.*** If you have any medical issue that is not requested below, but which you think is important, please include that information.

PART 1. GENERAL INFORMATION

Camper name: _____ Address: _____

Date of Birth _____/_____/_____ Gender: M _____ F _____

Parent/Legal Guardian name: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

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

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PART 2. MEDICAL INFORMATION

It is recommended that you consult with a physician prior to participating in this UTRGV Summer Camp. If you are uncertain about any pre-existing medical conditions, it is your responsibility to consult with your own physician prior to participating in this Summer Camp. Pleas 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: _____

Are you up to date with immunizations required by your school (circle one) Yes No
If you are participating in an overnight camp, a copy of your immunization record will be required.
Do you have health/accident insurance (circle one) Yes No If yes, please indicate policy number, name, and address of company. Please also include a copy of the back and front of your insurance card:

Company Name/Address _____ Policy Number: _____

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

Yes No If yes, identify and explain:

Is camper currently taking medication that may interfere with ability to safely participate in Camp?

Yes No If yes, identify and explain:

Does camper have a history of allergies or reactions to medications, insect stings, or plants?

Yes No If yes, identify and explain:

Does camper have a history of, or currently suffer from, medical conditions(s) with which we should be aware?

Yes No If yes, identify and explain:

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PART 3. AUTHORIZATION FOR MEDICAL CARE

Unless prior arrangements have been made, medical needs will be handled through Edinburg Regional Hospital, or Doctors Hospital at Renaissance. If traveling off campus, Camp Staff will select qualified facility. 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. Medical facilities will not perform services unless this signed medical release form.

_____(Camper's Name) has my permission to receive medical attention in the event of illness or medical emergency while participating in this UTRGV Summer Camp. I will assume financial responsibility for any cost of health care that may occur during this Camp.

PLEASE READ: As a participant, parent or guardian I understand and acknowledge that my failure to disclose relevant information may result in harm to myself/my child and/or others during this Camp. By signing my name I represent and warrant that I have provided all materials and important information to UTRGV pertaining to my child's medical, mental and physical condition and that it is accurate and complete. I agree to notify UTRGV of any changes in my/my child's mental, physical or medical condition prior to my child's scheduled Camp.

By revealing or disclosing the above medical information it will not be used by UTRGV personnel or employees to determine my child's ability to participate safely in activities. I understand that, if my child 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 my child.

SIGNATURE IS REQUIRED:

_____	_____	_____
Camper Name	Camper Signature	Date
_____	_____	_____
Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date
_____	_____	_____
UTRGV Witness Name	UTRGV Witness Signature	Date

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 18

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SUMMER CAMP MEDICATION PRESCRIBER/PARENT AUTHORIZATION

***UTRGV University Recreation Summer Youth Camp staff will not administer medication to campers.**

Camp Name: UNIVERSITY RECREATION SUMMER YOUTH CAMP

Date(s): _____ **Time(s):** 7:45am – 3:50pm & 3:50 – 6pm (Late Program)

CAMPER INFORMATION

Camper name: _____ Parent/Legal Guardian Name _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home phone _____ Work phone _____ Cell Phone _____ Email _____

____ **No, my child does not need to take any prescription medication while at Camp (if no, proceed to section C).**

____ **Yes, my child will need to take prescription medication while at Camp.**

This form must be completed fully in order for campers to administer required medication to themselves. A new medication administration form must be completed for each camp attended by the camper, for each medication, and each time there is a change in dosage or time of administration of a medication. Requires licensed health care authorization and signature and parent signature.

❑ 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 camper will be attending the Camp.

❑ *All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to Camp under the condition that the camper can self-manage care and delivery of medication with written authorization to do so at Camp by a licensed health care provider.*

A. 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 _____/_____/_____ to _____/_____/_____
Special Storage Requirements:
_____
Is the camper capable of self-managed care?
_____

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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 medications(s)
Prescriber's Signature: _____ Date: _____

B. PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

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 Institution, its governing board, officers, employees, and representatives 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 camper named above, including the administration of medication at the above referenced Camp.

Parent/Guardian Signature: _____ Date: _____
Home phone # _____ Cell Phone # _____ Work Phone # _____

C. PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR OVER-THE-COUNTER MEDICATION

Over-the-Counter (OTC) Medication may at times be administered, if approval is indicated by the camper'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 ANY medication.

____ **No, my child does not need to take any OTC medication while at Camp.**
____ **Yes, my child may need to take OTC medication while at Camp (if yes, complete the section below:**

I hereby authorize that the following medications may be given to _____ (Child's Name) if the need arises. You may dispense only those checked.

____ Ointments for minor wound care, first aid as directed. (antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
____ Tylenol/Acetaminophen as directed.
____ Aspirin/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.

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____ 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)
_____

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

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 camper'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 Institution, its governing board, officers, employees, and representatives 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 camper named above, including the administration of medication at the above referenced Camp.

Parent/Guardian Signature: _____ Date: _____

Home phone # _____ Cell Phone # _____ Work Phone # _____