Wilkes University

MEDICAL INFORMATION AND RELEASE FORM

PROGRAM INFORMATION

Program/Camp Name: _____

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. Wilkes University 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 Wilkes University does not offer any form of insurance for participant while participating in Program.

PART 1. GENERAL INFORMATION

Participant Name _____ (hereafter "Participant")

Parent/Legal Guardian Name _____

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? (Check one): YES NO

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

Company Name _____ Policy # _____

PLEASE ENCLOSE A COPY OF THE <u>FRONT AND BACK</u> 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
If yes, please explain:

Does participant have a history of food allergies? YES NO
If yes, please explain:

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.

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 Wilkes University pertaining to my Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify Wilkes University of any changes in mental, physical or medical condition prior Participant's scheduled Program.

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

Parent/Guardian Name (Please Print) _____

Parent/Guardian Signature _____

Date _____