



## TOPS Authorization to Administer Medication in Program

Camper Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Part I

Dear Parent,

When considered medically necessary, campers may receive medications and treatments as ordered by a licensed healthcare provider, during the camp day. Should the student display any adverse reactions, the parent will be contacted immediately, emergency care will be provided as needed and the medication/treatment discontinued. Please complete the following information.

- NO MEDICATION OR TREATMENT may be given by the program nurse or designee until this form is completed and properly labeled medication is received. THIS INCLUDES OVER THE COUNTER MEDICATIONS SUCH AS TYLENOL, MOTRIN, AND COUGH DROPS.
- A parent signature must be on this form.
- All medications must be stored in their original containers with an appropriate pharmacy label on each bottle. All labels will include the student’s name, does, frequency, route, time of administration of the medication.

### Part II

Medication Treatment #1:

Name of Drug/Treatment \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_ (include times and duration)

Medication form  pill/capsule     inhaler     ear drops     eye drops     liquid     injectable

Known adverse reactions/side effects \_\_\_\_\_

Prescribed treatment for side effects, if other than as outlined above \_\_\_\_\_

Medication Treatment #2:

Name of Drug/Treatment \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_ (include times and duration)

Medication form  pill/capsule     inhaler     ear drops     eye drops     liquid     injectable

Known adverse reactions/side effects \_\_\_\_\_

Prescribed treatment for side effects, if other than as outlined above \_\_\_\_\_

### Part III

Parent Permission:

I hereby give permission for my child to receive the above medications/treatments during camp hours, 9am-4pm. I understand that medications may be administered by the program registered nurse or designee. This designee may be a non-medical person. If a treatment requires a medical or nursing assessment prior to administration, and a licensed medical person is not available, the medication and/or treatment will not be given. This medication and/or treatment is considered a medical necessity and ordered by a licensed healthcare provider. I hereby release the FAUS District, its agents and employees from any and all liability that may result from my child receiving this medication and/or treatment.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Parent/Guardian Print

Office Use Only:

Secured in locked cabinet:  Yes  No



## TOPS Permission to Treat or Administer Emergency Medical Care/Authorization to Release Medical Information

I/We, the undersigned Parents/Guardians, in the event of an emergency, give permission for the evaluation and treatment, in our absence, of the above named student as deemed necessary by a currently licensed health care provider, hospital, emergency medical services or camp staff. Every effort will be made to contact the parent/guardian. Care of the injured student will be provided as needed. Care will not be withheld until parent arrives or are notified. I/We understand that the parent/guardian is completely responsible for the financial costs incurred with treatment.

I/We, the undersigned, authorize the release of medical information, gathered in the course of a camp emergency, to the listed medical care providers and emergency response personnel. I/We authorize the listed medical providers to share any "personal health care information" that will support the health of the camper while in program with the designated Health Care staff.

\_\_\_\_\_  
Signature of Parent/Guardian    Date    Signature of Parent/Guardian    Date

### Health Care Provider Information:

Pediatrician/Primary Health Care Provider: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Insurance Coverage  Yes  No  
Company/Carrier Name: \_\_\_\_\_

### Medical History:

My child will take daily or emergency medication during the program day.  Yes  No  
Name of drug, dose, frequency, time to be given, date drug therapy started or to be started for each med to be given.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A current "Authorization to Administer Medication in Program" form is completed by parent.  Yes  No  
Does your child routinely take daily medication at home?  Yes  No                      If yes, list the name, dose, time given, reason for administration, and any known side effects. \_\_\_\_\_  
\_\_\_\_\_

Does your child(ren) have any disease or chronic illness we should know about? Please list below.  
\_\_\_\_\_  
\_\_\_\_\_

Does your child currently have Asthma?  Yes  No If yes, list frequency of asthma attacks, date of last attack and meds taken: \_\_\_\_\_  
\_\_\_\_\_

Does your child currently have Allergies?  Yes  No    If your child has a strong allergic reaction to any substance, you are encourage to bring in a completed "Authorization to Administer Medication in Program" form for oral Benadryl and/or an injectable Epi-pen, Epi-pen Jr. These will be kept locked.

Food/Medication Allergies: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Reaction/Reaction Time: \_\_\_\_\_  
Contact Allergies (bug bites, airborne vapors, dust, pollen, lotions, latex, etc.): \_\_\_\_\_

Treatment: \_\_\_\_\_ Reaction/Reaction Time: \_\_\_\_\_

Has your child been diagnosed or treated for a vision, speech, or hearing impairment?  Yes  No

Does your child wear glasses/contacts or hearing aids:  Yes  No Explain: \_\_\_\_\_

Has your child been diagnosed or treated for behavioral, developmental, or learning disabilities?  Yes  No

If yes, please explain: \_\_\_\_\_

Does your child require assistance as defined by the Americans with Disabilities Act?  Yes  No

If yes, please explain: \_\_\_\_\_

**Medication Policy:**

All routine, regularly scheduled or as needed medications and treatments administered in the program setting must be authorized in advance by a licensed health care provider. This includes nebulizer or inhaler treatments for asthma, medications, ointments, or dressing changes to the skin and all over the counter medication (OTC's) such as Tylenol, Motrin, Cough Medicine, and Cough Drops. A note from the parent/guardian does not authorize the nurse or designee to provide these treatments. Before the nurse or designee can administer any medications or treatments the "Authorization to Administer Medication in Program" form must be completed by the parent/guardian. The parent/guardian must provide to the Director the prescribed medication stored in the original container with an appropriate pharmacy label on each bottle. All labels must include the camper's name, dose, route and time of administration of the medication.

No camper is permitted to carry any medication in his/her pocket or backpack unless special permission is granted. All medication will be kept secure in a locked cabinet in the TOPS Office and dispensed by the nurse or designee.

I/We have read and will abide by the program's medication policy. \_\_\_\_\_

**Parent/Guardian Signature**

**Date**



Florida Atlantic University Parental Permission Form and Release of Liability for
Pre-collegiate Programs TOPS Piano and Creative Writing Camp

I, \_\_\_\_\_, am the parent and/or legal guardian of
\_\_\_\_\_, a minor child under the age of 18 years. I would like
to have my child participate in the following PRE-COLLEGIATE PROGRAM at Florida Atlantic University
(UNIVERSITY): TOPS Piano and Creative Writing Camp which will take place from \_\_\_\_\_ to
\_\_\_\_\_.

In consideration for my child being allowed to participate in this PRE-COLLEGIATE PROGRAM, I the
undersigned, acknowledge, appreciate and agree that:

- 1. This PRE-COLLEGIATE PROGRAM affords my child the opportunity to participate in activities, including,
but not limited to: piano, creative writing, arts oriented classes, swimming and campus tours. There are
inherent risks involved with these activities, including but not limited to recreational incidents. I choose to
voluntarily allow my child to participate in this PRE-COLLEGIATE PROGRAM. I voluntarily assume full
responsibility for any risk of loss, property damage or personal injury, including death, which may be
sustained by my child as a result of his/her participation.
2. I certify that I have adequate health insurance necessary to provide for and pay for any medical costs that
may directly or indirectly result from my child's participation in this PRE-COLLEGIATE PROGRAM. I agree to
pay for any medical costs that exceed the limits of my insurance coverage.
I do not have medical insurance, but understand the University is not responsible for medical expenses
that may directly or indirectly result from my child's participation in this PRE-COLLEGIATE PROGRAM.
3. I certify that my child is physically fit to participate and I know of no medical reason why my child should
not participate.
4. I hereby release, waive, and discharge Florida Atlantic University and its Board of Trustees, its officers,
agents, employees and representatives from all claims, demands, liabilities, rights and causes of action of
whatever kind or nature, that may result from or occur during my child's participation in this PRE-
COLLEGIATE PROGRAM, whether caused by negligence of the UNIVERSITY, its Board of Trustees, officers,
agents, employees or representatives or otherwise. I also agree to indemnify and hold harmless the
UNIVERSITY for any loss, liability, damage or costs, including court costs and attorney's fees that may occur
as a result of my or my child's negligent or intentional act or omission while participating in this PRE-
COLLEGIATE PROGRAM.

I HAVE CAREFULLY READ THIS PERMISSION AND RELEASE OF LIABILITY AND HAVE HAD SUFFICIENT TIME
TO SEEK EXPLANATION OF THE PROVISIONS CONTAINED HEREIN, AND TO DISCUSS ANY QUESTIONS OR
CONCERNS I MAY HAVE WITH THE UNIVERSITY OR ITS AFFILIATE. AFTER CAREFUL CONSIDERATION, I
SIGN THIS DOCUMENT VOLUNTARILY AND WITHOUT ANY INDUCEMENT.

\_\_\_\_\_  
Signature of Parent and/or Legal Guardian

\_\_\_\_\_  
Date



### TOPS Photograph and Publicity Release Form

I, \_\_\_\_\_, give TOPS (Teaching Outstanding PerformerS) Piano and Creative Writing Camp and its fiscal agent, Florida Atlantic University, permission to use my child's name, likeness, image, voice, and/or appearance as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, taken or made on behalf of the TOPS Program. I agree that the TOPS has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the TOPS mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc for the use of such pictures, etc., and hereby release the TOPS and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

I have read and understood this consent and release.

**I give my consent** to TOPS to use my child's name and likeness to promote the TOPS program, its fiscal agent, and/or their activities.

**I do not give my consent** to TOPS to use my child's name and likeness to promote the TOPS program, its fiscal agent, and/or their activities.

\_\_\_\_\_  
Parent / legal guardian (if age 17)

\_\_\_\_\_  
Date