SciFi Collab Lab 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 mediations 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

SciFi Collab Lab 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**

SciFi Collab Lab Photograph and Publicity Release Form

I, _____, give SciFi Collab Lab 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 SciFi Collab Lab Program. I agree that the SciFi Collab Lab has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the SciFi Collab Lab 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 SciFi Collab Lab 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 SciFi Collab Lab to use my child's name and likeness to promote the SciFi Collab Lab program, its fiscal agent, and/or their activities.

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

_____ _____

Parent / legal guardian (if age 17) Date

Florida Atlantic University Parental Permission Form and Release of Liability for

Pre-collegiate Programs SciFi Collab Lab

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): SciFi Collab Lab which will take place from ____June 26, 2017____ to___June 30, 2017_____.

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: creative writing. 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