FAU FLORIDA ATLANTIC UNIVERSITY

Spanish Summer Camp 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**