The Pennsylvania State University *Youth Program Consent for Treatment*

This form must be completed and returned before youth camp/program/event enrollment dates in order for youth to be permitted to participate in any program activities.

Personal Information

Youth's Last Name_____ First Name_____ Birthdate_____ ☐ M ☐ F

Specify program your child will be attending _____

Address_____ City_____ State_____ Zip _____

Home Phone_____ E-mail Address _____

Parent/Guardian #1_____ Parent/Guardian #2_____

Daytime Phone_____ Daytime Phone _____

Place of employment_____ Place of employment _____

Health Insurance Carrier_____ Policy Number_____

Plan Number_____ Is physician authorization needed? ☐ Yes ☐ No

Name of Family Physician_____ Phone _____

In case of emergency, please notify

If neither parent nor guardian is available in an emergency, please contact:

1. _____ Phone _____

2. _____ Phone _____

Health History [Please check and provide approximate dates that youth suffered from allergies and other conditions listed below]

Allergies

☐ Hay Fever ☐ Bee/Wasp Stings ☐ Insect Stings ☐ Penicillin ☐ Peanut ☐ Other Food/Drugs: _____

Other

☐ Asthma ☐ Diabetes ☐ Convulsions ☐ Concussion ☐ Behavioral/Emotional ☐ Other: _____

Date of most recent tetanus immunization: _____

Please list any ***major*** past illnesses (contagious and non-contagious): _____

Please list any ***major*** operations or serious injuries (include dates): _____

Has the youth ever been hospitalized? ☐ NO ☐ Yes If YES, explain: _____

Does the youth have any chronic or recurring illness? ☐ NO ☐ Yes If YES, explain: _____

Is there anything else in youth's health history that the program staff should know? _____

Are there any activities from which the youth should be restricted? ☐ NO ☐ Yes If YES, explain: _____

Are there any specific activities that should be encouraged? ☐ NO ☐ Yes If YES, explain: _____

Does the youth have any special dietary restrictions? ☐ NO ☐ Yes If YES, explain: _____

Does the youth wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? ☐ NO ☐ Yes If YES, explain: _____

Will the youth need to take any medication during the program? ☐ NO ☐ Yes

If YES, please list the specific prescription or over-the-counter medications below, reasons for medication, and daily dosage. If any medications change prior to arriving at the program, please provide an updated list upon arrival.

	Medication	***Reason(s) for Medication***	***Daily Dosage/Time(s) Taken***
1.			
2.			
3.			
4.			

If at all possible, medication should be administered at home. Medications will be allowed at the Youth Program only when failure to take such medicine would jeopardize the health of a child and he/she would not be able to attend the Youth Program if the medicine were not made available.

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Youth's Last Name_____ First Name_____ Birthdate_____ ☐M ☐F

The parent(s)/legal guardian(s) of Youth Program participants are required to disclose their intention to bring medications to the Program, especially to treat potentially life-threatening conditions (i.e. inhalers, EPI-pens, insulin injections). Upon arrival to the Program, parent(s)/legal guardian(s) should plan to meet with a member of the Youth Program staff at registration to review medication issues for a Youth Program participant and complete additional required paperwork if not completed prior to arrival. For identification purposes, a current picture of the child is to be provided upon registration.

All medications (prescription and over-the-counter) must be stored in the original product packaging and clearly labeled with the participant's name. Prescription medication(s) must also include a label with the medication's name and dosage instructions, as well as the prescribing physician's name and telephone number.

All medications will be kept in a securely locked cabinet used exclusively for storage of medications. Medications that require refrigeration will be stored and locked in a refrigerator designated for medications **ONLY**. Access to all medications will be limited to approved personnel. The need for emergency medication may require that a Youth Program participant carry the medication on his/her person or that it be easily accessed (i.e. inhalers, EPI-pens, insulin injections). Penn State Youth Program staff will **NOT** purchase medications of any type (prescription or over-the-counter) for Youth Program participants of any age.

If a Program has professional medical staff on-site, then the medical staff may administer over the counter medications (e.g., ibuprofen or Tylenol) supplied by the parent(s)/guardian(s) per package instructions. Medical staff may monitor the self-administration of medications, if necessary, upon written consent of the parent(s) and/or legal guardian(s) and/or physician orders.

If there are no medical staff on-site, Penn State Youth Program staff ***will not*** dispense medications, but may monitor the self-administration of certain medications if necessary, ***ONLY*** upon written consent of the parent(s)/legal guardian(s) and /or physician's orders.

It is NOT permissible for a participant to share any medications with any other participants.

It is the responsibility of the parent(s)/legal guardian(s) to be sure that the participant's medications brought to the Youth Program are not left behind at the end of the Program. Failure to do so will result in the medications being destroyed within three working days after the participant's last day at the Program. Absolutely no medications will be returned via mail regardless of circumstance.

I understand that all Youth Program participants are recommended to have a meningococcal vaccination prior to attending the program.

I hereby authorize the clinical staff at The Pennsylvania State University ("Penn State" or the "University") (e.g., clinical staff at Penn State University Health Services) or other licensed health care practitioners, acting within the scope of his or her practice under State law, to provide medical care that includes routine diagnostic procedures (e.g., x-rays, blood and urine tests) and medical treatment as necessary to my minor daughter/ son/dependent. I understand that the consent and authorization herein granted does not include major surgical procedures and is valid only during the Youth Program/event.

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and if I cannot be reached, I give my consent for Penn State University Health Services staff or other licensed health care practitioners to perform any necessary emergency treatment.

I agree to the release of records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. If treatment is provided by Penn State, I understand that the University charges for services and that it is my responsibility to pay the bill. I may be responsible to submit any claims to my health insurance carrier for reimbursement. I also authorize Penn State to receive medical/billing information and submit it to the University's insurance carrier.

I understand that, unless specifically stated otherwise in the Penn State Youth Program/event literature, Penn State does not provide medical insurance to cover emergency care or medical treatment of my child.

I understand that, in accordance with Youth Program policy, any medication(s) should be given at home before and/or after the Youth Program. However, when this is not possible, and medications will be brought to Youth Program camp, I agree to the provisions outlined above relating to the management of medications.

Medical and Related Health Information Penn State is committed to protecting the medical and related health information about your child. Medical and related health Information provided on this form will only be used as Penn State deems necessary to provide services for your child while participating in the Youth Program. Information will be stored, archived, and disposed of according to Policy AD35, University Archive and Records Management and Policy AD95, Information Assurance and IT Security.

Parent/Legal Guardian Name (Please Print) Parent/Guardian Signature

Date *Terms and Conditions agreed to via electronic signature

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