Print Clear

County Name: _____ *Club Name:* _____

Penn State University Youth Program Health Services Medical Treatment Authorization

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: _____

Health dates or comments: _____

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? _____

Does the youth have any chronic or recurring illness? _____

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? _____

Are there any specific activities that should be encouraged? _____

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.

Penn State University Youth Program Health Services Medical Treatment Authorization Page 2

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 of University Health Services or other licensed practitioner of the healing arts, 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 are 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 physicians and staff at University Health Services or other licensed practitioners of the healing arts to perform any necessary emergency treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. I understand that University Health Services does charge for services and that it is my responsibility to pay the bill if a claim can't be submitted by the University Health Services to my private insurance. As applicable, I may be responsible to submit any claims to my health insurance company for reimbursement. I authorize The Pennsylvania State University 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, The Pennsylvania State University does not provide medical insurance to cover emergency care or medical treatment of my child.

I understand that, in accordance with Youth Program policy, the 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.

HIPAA

Penn State honors the privacy of the participants in its Programs and complies with the national regulations regarding health information. Follow this computer link to the University Health Services Notice of Privacy Practices.
http://studentaffairs.psu.edu/health/welcome/confidentiality/noticeOfPrivacyPractices.shtml)

_____ _____

Parent/ Legal Guardian Name (please print) Parent/ Legal Guardian Signature

* Terms and Conditions agreed to via electronic signature

Date: _____

Revised January 21, 2015