STETSON UNIVERSITY

Adult In-Person Program Consent for Emergency Medical Treatment

Applicable University Sponsored Program: _____

Program Dates: _____ Program Location: _____

All participants must submit this form prior to the start date of the Program. All health and medical information is confidential and will not be released, unless legally required, without consent and is not used to discriminate, to deny healthcare, or to affect admission status. Medical and related health Information provided on this form will only be used as Stetson deems necessary to provide services for you while participating in the Program.

Participant Information

Last Name _____ First Name _____ Date of Birth _____ ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Emergency Contact #1 Name _____ Emergency Contact #2 Name _____

Emergency Contact #1 Phone Number _____ Emergency Contact #2 Phone Number _____

Health Insurance Carrier _____ Policy Number _____

Plan Number _____ Is physician authorization needed? ☐ Yes ☐ No

Name of Family Physician _____ Family Physician Phone Number _____

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

Allergies

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

Additional Information: _____

Other

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

Additional Information: _____

Do you have any medical issues the Program staff should be aware of? ☐ Yes ☐ No

If yes, please explain: _____

Are there any activities from which you should be restricted? ☐ Yes ☐ No

If yes, please explain: _____

Does you have any special dietary restrictions? ☐ Yes ☐ No

If yes, please explain: _____

Does you wear any medical appliances (glasses, orthodonture, etc.)? ☐ Yes ☐ No

If yes, please explain: _____

Will you need to take any medication during the program? ☐ Yes ☐ No

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

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

Participant Signature: _____ Date: _____

STETSON UNIVERSITY

Adult In-Person Program Consent for Emergency Medical Treatment

Participant Name: _____ Participant Date of Birth: _____

Applicable University Sponsored Program: _____

Program Dates: Program Times:

I, the undersigned, state that I am seeking to participate in the above referenced Stetson University, Inc. (hereafter "Stetson") Program (hereafter "Program"). I wish to participate in the above referenced Program on the date(s) indicated above and, in consideration for my participation, I hereby agree as follows:

I acknowledge that I must be able to self-administer all prescription and non-prescription medications if they are needed during the Program. The Program does not assist participants in taking their prescription or non-prescription medications unless it is necessary for emergency treatment, nor does the Program remind participants to do so.

I acknowledge that all prescription medications, including medications for conditions such as food, drug, or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that I can self-manage care and delivery of medication. All medications (prescription and over-the-counter) must be stored in the original product packaging and clearly labeled with my 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.

I acknowledge that I am required to disclose my 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, I must meet with a member of the Program staff at registration to review my medication issues. I understand that it is NOT permissible for me to share any medications with any other participants.

I acknowledge the need for emergency medication may require that a Program participant carry the medication on their person or that it be easily accessed (i.e. inhalers, EPI-pens, insulin injections). Program staff will NOT purchase medications of any type (prescription or over-the-counter) for Program participants of any age.

I hereby authorize the Program Staff 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. I understand that the consent and authorization herein granted does not include major surgical procedures and is valid only during the Program. In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact my emergency contacts. However, in the event of an emergency and if they cannot be reached, I give my consent for Stetson Program staff or other licensed health care practitioners to perform any necessary emergency treatment.

I acknowledge that it is my responsibility to provide medical coverage, and/or provide any payments for medical costs that may arise as a result of injuries related to Program activities, including those costs that may exceed or be excluded from a Stetson accident insurance policy if applicable. I hereby consent and give my permission to be treated for emergency medical care and first aid by a medical facility and/or clinic personnel at their discretion, and release them from liability for such decisions. I certify that I have completed the medical information on Page 1 of this form as well.

I furthermore release, indemnify and hold harmless Stetson from and against any and all liability, actions, debts, claims and demands of every kind whatsoever, specifically including, but not limited to, any claim for negligence or negligent acts or omissions and any present or future claim, loss or liability for injury to person or property that I may suffer, for which I may be liable to any other person, that may or does arise out of my participation in the Program.

This consent shall be governed by and construed under the laws of Florida. I agree that any legal action or proceeding relating to this RELEASE, or arising out of any injury, death, damage or loss as a result of my participation in any part of the Program, shall be brought only in Volusia County, Florida.

Participant Signature: Date: