



Youth 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 your child while participating in the Program.

Participant Information

Last Name _____ First Name _____ Date of Birth _____ M F
 Address _____ City _____ State _____ Zip _____
 Parent/Guardian #1 Name _____ Parent/Guardian #2 Name _____
 Parent/Guardian #1 Phone Number _____ Parent/Guardian #2 Phone Number _____
 Health Insurance Carrier _____ Policy Number _____
 Plan Number _____ Is physician authorization needed? Yes No
 Name of Family Physician _____ Family Physician Phone Number _____

In case of emergency, if neither parent nor guardian is available, please contact:

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

Does the participant have any medical issues the Program staff should be aware of? Yes No

If yes, please explain: _____

Are there any activities from which the Participant should be restricted? Yes No

If yes, please explain: _____

Does the Participant have any special dietary restrictions? Yes No

If yes, please explain: _____

Does the Participant wear any medical appliances (glasses, orthodonture, etc.)? Yes No

If yes, please explain: _____

Will the Participant 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.

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Printed Name: _____



Youth 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 the natural guardian/parent of the minor child (hereafter "Child") seeking to participate in the above referenced Stetson University, Inc. (hereafter "Stetson") Youth Program (hereafter "Program"). I wish for my Child to participate in the above referenced Program on the date(s) indicated above and, in consideration for my Child's participation, I hereby agree as follows:

I, on behalf of my Child, acknowledge that my Child 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, on behalf of my Child, 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 my Child can self-manage care and delivery of medication with written authorization to do so at the Program by a natural guardian/parent. All medications (prescription and over-the-counter) must be stored in the original product packaging and clearly labeled with my Child'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.

The natural guardian/parent of 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, natural guardian/parent shall plan to meet with a member of the Program staff at registration to review medication issues for their Child. It is NOT permissible for a participant to share any medications with any other participants.

I, on behalf of my Child, 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, on behalf of my child, 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 me. However, in the event of an emergency and if I cannot be reached, I give my consent for Stetson Program staff or other licensed health care practitioners to perform any necessary emergency treatment.

I, on behalf of my Child, 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, on behalf of my Child, hereby consent and give my permission for the participant may 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, on behalf of my Child, 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 my Child may suffer, for which my Child may be liable to any other person, that may or does arise out of my Child's 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 consent, or arising out of any injury, death, damage or loss as a result of my Child's participation in any part of the Program, shall be brought only in Volusia County, Florida.

This consent contains the entire agreement between the parties to this agreement and the terms of this consent are contractual and not a mere recital. The information I have provided is disclosed accurately and truthfully. I have been given ample opportunity to read this document and I understand and agree to all of its terms and conditions. I understand that I am giving up substantial rights (including my right to sue), and acknowledge that I am signing this document freely and voluntarily, and intend by my signature to provide a complete and unconditional release of all liability to

the greatest extent allowed by law. My signature on this document is intended to bind not only myself and my Child but also the successors, heirs, representatives, administrators, and assigns of myself and my Child.

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF STETSON USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM STETSON IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND STETSON HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

Parent/Legal Guardian Signature: _____	Date: _____
Parent/Legal Guardian Printed Name: _____	