THE UNIVERSITY OF MEMPHIS

PROGRAM PARTICIPATION AND PARENTAL CONSENT

Participant Information

Full Name of Child (First/Middle/Last): _____

Date of Birth: ___/___/_____ Gender: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Alternate Phone: ( )_____

Required Emergency Medical Information

Health Insurance: Y N Company: _____ Policy #: _____

Primary Insured: _____

Family Physician: _____ Office Phone: ( )_____

Emergency Contact(s)

Emergency Contact #1: _____ Relation: _____

Home / Work Phone: ( )_____ Cell Phone: ( )_____

Emergency Contact #2: _____ Relation: _____

Home / Work Phone: ( )_____ Cell Phone: ( )_____

Parent Information

Name of Parent/Legal Guardian: _____

Address (if different than Participant): _____

City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Alternate Phone: ( )_____

Email Address: _____

Media Release

I hereby authorize the University of Memphis and those acting pursuant to its authority to: record my Child's likeness and voice in any medium; use my Child's name in connection with those recordings; and use, reproduce, exhibit, or distribute in any medium these recordings for any purpose that the University deems appropriate, including promotional or advertising efforts, without payment of fees, royalties, special credit, or other compensation.

I release the University from liability of any violation of any personal or proprietary right I or my Child may have in connection with such use. I understand that all such recordings, in whatever medium, shall remain the property of the University.

Assumption of Risk

I realize and appreciate the risks in allowing my Child to participate in the program sponsored by the University of Memphis. These risks may include personal and/or economic harm, as well as harm to property. I further realize that these risks may be presently known and unknown, but I have chosen to allow my Child to participate in the program. Therefore, I, on behalf of my Child, voluntarily accept

and assume all risk of injury, loss of life, or damage to property arising out of training, preparing, participating, and traveling to or from the program.

Exculpatory and Indemnification Clause

I, on behalf of my Child, hereby release the University of Memphis, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, the Event Staff, and all other officers, directors, employees, volunteers and agents from any and all liability as to any right of action that may accrue for any injury to my Child or loss that my Child may suffer while training, preparing, participating, and/or traveling to or from the program.

I, on behalf of my Child, further release, indemnify, and hold harmless the University from and against any and all liability, actions, debts, claims, and demands of every kind whatsoever. I understand that the University accepts no responsibility for my Child's personal property.

Medical Acknowledgment and Consent

I recognize that there may be occasions where my Child may be in need of first aid or emergency medical or dental treatment as a result of an accident, illness, or other health condition or injury. I hereby give my consent/authority for Program Staff to administer or obtain the necessary emergency medical treatment for my child with the understanding that I will be notified as soon as possible. In so doing, I agree to pay all fees and costs arising from this action to obtain medical treatment.

SIGNATURE REQUIRED: I have read, understood, and freely agreed to the information above.

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____

Date: ___/___/_____

THE UNIVERSITY OF MEMPHIS
MEDICAL INFORMATION/SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Program Information
Program Name: _____

Participant Information
Participant's Name: _____

Participant's Date of Birth: _____ Participant's Age: _____

Medical Conditions (check all that apply):
____ Asthma ____Heart Conditions ____Diabetes ____Hypoglycemia ____Pregnancy
____Seizures ____Back/Neck Injuries ____Broken Bones (recent) ____Dizziness/Vertigo
____Insect Stings (severe) ____Other (explain) _____
____ Allergies (list) _____
Briefly explain any items checked and how the item might impact program participation.
_____
_____
_____

Dietary Restrictions
Please identify any dietary restrictions such as vegetarian/kosher/gluten free/peanut free/tree nut free/etc. Explain and identify how we can best accommodate the dietary restriction, if certain foods cause an allergic reaction, and how staff is to respond to the reaction.
_____
_____
_____
_____

Medication
This form must be completed fully in order for participants to self-administer required medication. A new medication administration form must be completed for each program attended by the participant, for each medication, each time there is a change in dosage or time of administration of a medication and/or at three (3) month intervals. Self-medication requires licensed health care authorization and signature and parent signature.

□ My child does not need to take any medication while at the program/camp.

□ My child will need to take medication while at the program/camp.

□ My child needs to keep this medication with him/her at all times for emergency care.

Important Information
All medications must be in the original prescription container and are to be given to staff for safekeeping with the exception of asthma inhalers and EPI pens that stay with participant. Fill out the attached form detailing the name of the medication and when and how it is to be given. Staff will dispense and log the medications according to parental instructions.

Waiver and Release
I hereby acknowledge that camp personnel are not trained medical professionals and cannot guarantee nor be responsible for a satisfactory outcome of the administering of medication. In consideration of permitting my child to participate in the program/camp above, I hereby for myself, my child, and our executors administrators and assignees, assume all risks and hold the University of Memphis, its agents, members of the Board of Trustees, employees, representatives, all sponsors, affiliates, parties permitting use of property for the program/camp, coordinating groups, volunteers, and any individuals associated with the program/camp harmless from any and all liability, causes of action, debts, claims, damages, or demands of any nature whatsoever which may arise in connection with my child's participation in activities related to the program/camp.

_____

Parent/Guardian Signature Date

THE UNIVERSITY OF MEMPHIS
PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Participant Information

Participant's Name: _____

Participant's Date of Birth: _____ Participant's Age: _____

Medication Information

Medication Name: _____ Dose: _____

Specific Directions: _____

Time/Frequency of Administration: _____

If as needed, for what symptoms? _____

Medication Name: _____ Dose: _____

Specific Directions: _____

Time/Frequency of Administration: _____

If as needed, for what symptoms? _____

Medication Name: _____ Dose: _____

Specific Directions: _____

Time/Frequency of Administration: _____

If as needed, for what symptoms? _____

This form must be signed by a licensed healthcare provider authorizing self-administration of the above-referenced medication.

_____

Prescriber's Signature Date
(Original Signature or Signature Stamp Only)