Youth Program Medical Information Form

Participant Name: _____ **Date of Birth:** _____

Program/Activity Name: Viola Day @ UA **Program Date:** 9/10/22

Instructions

The University of Alabama requests the information on this form so we will have accurate information in the event of an emergency. It is recommended that you consult with a physician prior to participating in this program. If the participant has a pre-existing medical condition, participation in any strenuous activity may not be recommended. You are accountable for providing an accurate medical history, but final determination about appropriateness of participation is the responsibility of you and your physician.

Please answer all questions below. If the participant has any medical issue that is not specifically covered below, but which you think is important, please include that under Additional Information.

Parent/Guardian Information

Name of Parent/Legal Guardian: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone Number: _____ **Alternate Phone Number:** _____

Email: _____

Emergency Contact Information

Primary Person to notify in case of emergency: _____ **Relationship:** _____

Contact's Phone Number(s): _____, _____

Secondary Person to notify in case of emergency: _____ **Relationship:** _____

Contact's Phone Number(s): _____, _____

Family Physician: _____ Phone Number: _____

Insurance Information

If your child is covered by family medical/hospital insurance, please provide the details below. This will assist us in making the appropriate billing arrangements in the event that your child needs medical care. Insurance coverage is not a requirement for participation in the program.

Insurance Provider: _____ **Phone Number:** _____

Insurance subscriber name: _____ **Subscriber date of birth:** _____

Policy Number: _____

I understand that The University of Alabama does not offer any form of health, liability, or other insurance coverage for participants. (Please initial: _____)

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Immunization History

Although immunizations are not required for participation, we strongly encourage that program participants are appropriately immunized for, at minimum, the following diseases: tetanus, measles, mumps, rubella (MMR), meningococcal meningitis.

By signing below, I acknowledge and accept the following:

Because immunizations are not required, program participants may be exposed to individuals who have not been immunized and/or individuals who may carry infectious diseases, which may result in a program participant contracting an infectious disease. I understand and accept the risks to my child that relate to and arise from potential exposure to and contraction of an infectious disease.

Signature of Parent/Guardian:_____ **Date:**_____

Medical Concerns

Please list any current medical concerns or medical history we need to know about your child: (Ex. past injuries, current conditions, physical limitations, etc.) _____

_____

List any allergies: (Ex. medications, bee stings, food, latex, plants, etc.)_____

_____

Will your child need to take medication(s) during the program? ____Yes ____No

Please complete a Medication Management Form for each medication, place the completed form(s) with the medication(s) in a zip-top bag clearly labeled with the participant's name and date of birth, and provide the bag to a program staff member at check-in. These medications will be secured and provided to the child as described on the Medication Management Form. Please consult with the program director if your child has medication(s) that must stay with them at all times.

Does your child have a disability that requires reasonable accommodations to enable them to participate in the program/activity?
____Yes ____No

To request reasonable accommodations, contact the UA Office of Compliance, Ethics, and Regulatory Affairs at (205) 348-2334 or youthprotection@fa.ua.edu. Requests should be submitted in writing at least 30 days prior to the event. Late requests may not be accommodated due to time constraints.

If accommodations are requested, I give The University of Alabama permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include sharing information with appropriate University personnel, and I acknowledge that such communication is consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. (**Please initial:** _____)

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Additional Information

Please provide any additional information or explanation that you feel could be relevant or beneficial for our staff to know in supporting your child during this program. (Attach additional information, if necessary.)

Authorization for Medical Care

I understand that my child is voluntarily participating in a program at The University of Alabama. By signing this form, I hereby acknowledge that all information is accurate and current, and, to the best of my knowledge, my child is capable of participating safely in this program. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program. I agree to notify the program/activity of any changes in my child's mental, physical, or medical condition before the program begins.

In the case of accident or illness, I hereby authorize the program/activity staff to administer or seek medical treatment for my child, as they see fit, including routine first aid care or emergency medical treatment. However, I understand and acknowledge that such staff are not medical professionals. I hold harmless and agree to indemnify the program, The Board of Trustees of the University of Alabama and its agents and employees, from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment or lack thereof. I acknowledge that I am solely responsible for any hospital or other costs arising out of any illness, bodily injury or property damage sustained through my child's participation in such voluntary program.

Signature of Parent/Guardian: _____ **Date:** _____

Parent/Guardian Name: _____