Appendix A

Cleveland State University Youth Program/Camp Medical Information and Release Form

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PROGRAM/CAMP INFORMATION

Program/Camp Name ______________________________________(hereafter "Program")

Date(s): _____________________________________Time(s): ______________________

Location: ____

As a student, parent(s) or guardian(s) I/we understand that the information requested on this form is intended to help inform program staff of any pre-existing medical conditions. If Participant has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. This information will be kept in strict confidence and will only be shared with your permission. Cleveland State University requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment for Participant. You are accountable for providing an accurate medical history. Final determination about whether to participate is the responsibility of you and your physician. If Participant has any medical issue that is not requested below, but which you think is important, please include that information. It is recommended that you consult with a physician prior to participating in this Program. If you are uncertain about any preexisting medical conditions, it is your responsibility to consult with your own physician prior to participating in this Program. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated. Use back and/or additional paper if needed.

I understand that Cleveland State University does not offer any form of insurance for

participant while participating in Program.

PART 1. GENERAL INFORMATION

Participant Name ______________________________________(hereafter "Participant")

Parent/Legal Guardian Name (if applicable) ____________________________________

Parent/Legal Guardian Name (if applicable) ____________________________________

Street Address_________________________City_____________State _______ Zip______

Home Phone ( )_________________Work Phone ( )__________________________

Date of Birth ____________________ Male _____ Female _____

Please list two emergency contacts:

Emergency Contact #1:

Home Phone Work Phone Cell Phone Relationship

____

Emergency Contact #2:

Home Phone Work Phone Cell Phone Relationship

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PART 2. MEDICAL INFORMATION

It is recommended that Participant consult with your physician prior to participating in this Program. If you are uncertain about any preexisting medical conditions, it is your responsibility to consult with your own physician prior to participating in this Program. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated. Use back and/or additional paper if needed.

Physician's Name _______________________ Phone Number ( ) ___________

Date of most recent tetanus toxoid immunization _______________________________

Do you have health/accident insurance? (circle one): YES NO

If yes, please indicate policy number, name and address of insurance company.

Company Name / Address ____________________________Policy #_____________

PLEASE ENCLOSE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD WITH THIS FORM

For the following, circle appropriate response and explain as appropriate:

Does participant have any limiting medical conditions that you or your doctor feel would limit camp participation? YES NO

If yes, identify and explain:

Is participant currently taking medication that may interfere with ability to safely participate in Program? YES NO

If yes, please indicate the medication and the condition being treated:

Does participant have a history of allergies or reactions to medications, insect stings, or plants? YES NO

If yes, please explain:

Does participant have a history of food allergies? YES NO

If yes, please explain:

Does participant have a history of, or currently suffer from, medical condition(s) with which we need to be aware? YES NO

If yes, please explain:

PART 3: AUTHORIZATION FOR MEDICAL CARE

Participant has my/our permission to receive medical attention in the event of illness or medical emergency while participating in this Program. I/We will assume the financial

responsibility for any cost of health care for my/our child that may occur during this Program.

As a participant, parent, or guardian I/we understand and acknowledge that my/our failure to disclose relevant information may result in harm to Participant and/or others during this Program. By signing my/our name(s) I/we represent and warrant that I/we have provided all materials and important information to Cleveland State University pertaining to my/our Participant's medical, mental and physical condition and that it is accurate and complete. I/we agree to notify Cleveland State University of any changes in my/our mental, physical or medical condition prior Participant's scheduled Program.

By revealing or disclosing the above medical information it will not be used by Cleveland State University personnel or employees to determine Participant's ability to participate safely in activities. I/We understand that, if Participant chooses to participate in activities, he/she do so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of myself/ourselves and Participant.

Participant Name ____

Parent/Guardian Name____________________________________

Parent/Guardian Name ____________________________________

Participant's Signature __ ____________________________ Date _______________

Parent/Guardian Signature ____________________________ Date _______________

Parent/Guardian Signature ____________________________ Date _______________

PARENT(S) OR GUARDIAN(S) MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF EIGHTEEN (18).