2015 Chinese Summer Immersion Camp
Lease Waiver Form

Notes:

1. Please fill in with Print names, mail and email addresses;
2. Please mail the form with check (pay to “CSU Foundation”, memo “2015 Chinese Summer Immersion Camp”, amount $120);
3. Mail Address: RT1214-A, 2121 Euclid Ave, Cleveland, OH 44115
Appendix A

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

PROGRAM/CAMP INFORMATION

Program/Camp Name __________________________________________ (hereinafter “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:

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Relationship</th>
</tr>
</thead>
</table>

Emergency Contact #2:

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Relationship</th>
</tr>
</thead>
</table>

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).
Appendix B:

Cleveland State University Youth Program/Camp Parent/Guardian Authorization,
Waiver and Consent for Over-the-Counter Medication Form

PROGRAM/CAMP INFORMATION

Program/Camp Name: __________________________ (hereafter “Program”)
Date(s): ____________ Time(s): ____________ Location: _______________

PARTICIPANT INFORMATION

Participant Name: __________________________ (hereafter “Participant”)
Parent(s)/Legal Guardian(s) Name (if applicable): ______________________

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant’s parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay.

Note: Unless we have parental authorization, we CANNOT administer ANY medications.

I/We hereby authorize that the following medications may be given to Participant if the need arises. You may dispense only those checked.

___ Ointments for minor wound care, first aid as directed. (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)

___ Tylenol/Acetaminophen as directed.
___ Ibuprofen as directed.
___ Throat lozenges and or spray as directed for sore throat.
___ Micatin or anti-fungus treatment as directed for athlete’s foot.
___ Kapectate or Imodium for diarrhea as directed.
___ Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea as directed.
___ Rolaid or Tums for acid reflux, heartburn or indigestion as directed.
___ Benadryl for swelling, hives, allergic reaction, as directed.
___ Actifed or Sudafed as directed for nasal congestion or allergy relief per instructions.
___ Visine or other eye drops for minor eye irritation.
___ Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
___ Swimmer’s ear drops as directed.
___ Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.
___ Medicated powder for skin irritation as directed.
___ Robitussin or other cough syrup as directed.
___ Calamine lotion for bug bites and poison ivy.
___ Sunscreen
___ Bug repellent
Other (list any other approved over-the-counter drugs)

Program staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above.

I/We understand that such administration will not be done under the supervision of medical personnel. I/We also agree that any first aid treatment may be given as needed.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the student’s parents/guardians. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I/We understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

I/We authorize the administration of over-the-counter medications to my/our child as indicated above. I/We shall indemnify and hold harmless the Program Staff, the State of Ohio, Cleveland State University, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my/our child being administered the above indicated over-the-counter medications. I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at the above referenced program.

Participant Name __________________________________________
Participant’s Signature ______________________________________ Date ____________

Parent/Guardian Name ______________________________________
Parent/Guardian Signature ______________________________ Date ____________

Parent/Guardian Name ______________________________________
Parent/Guardian Signature ______________________________ Date ____________
Appendix B (cont.) Cleveland State University Youth Program/Camp Parent/Guardian Authorization, Waiver and Consent for Self-Administration of Prescription Medication Form

PROGRAM/CAMP INFORMATION

Program/Camp Name: ___________________________ (hereafter “Program”)

Date(s): _______________ Time(s): ____________ Location: _______________

PARTICIPANT INFORMATION

Participant Name: _______________________________ (hereafter “Participant”)

Parent(s)/Legal Guardian(s) Name (if applicable): ______________________________

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, and each time there is a change in dosage or time of administration of a medication. Self-medication requires licensed health care authorization and signature, and parent signature

_____ No, my child does not need to take any prescription medication while at the Program.

_____ Yes, my child will need to take prescription medication while at the Program.

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 the participant can self-manage care and delivery of medication with written authorization to do so at camp by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the participant will be attending the Program.
PREScriber AUTHORIZATION

foR SELF ADMINISTRATION oF PRESCRIPTION MEDICATION

Medication Name: ___________________ Dose: ___________________

Condition for which medication is being administered: ___________________

Specific Directions (e.g., on empty stomach/with water, etc.): ___________________

Time/frequency of administration: ___________________

If PRN, frequency: ___________________

If PRN, for what symptoms: ___________________

Relevant side effects: ___________________

Medication shall be administered from (date): ___________________

Special Storage Requirements: ___________________

Is the participant capable of self-managed care: YES NO

Prescriber’s Name/Title: ___________________ Prescriber’s Place of Employment: ___________________

Telephone: ( ) ___________________ Fax: ( ) ___________________

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medication(s).

Prescriber’s Signature: ___________________ Date: ___________________

I/we authorize and recommend self-medication by my child for the above medication.

I/we also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I/we shall indemnify and hold harmless the Program Staff, the State of Ohio, Cleveland State University, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors,
employees and agents against any claims that may arise relating to my/our child's self-administration of prescribed medication(s). I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced Program.

Parent/Guardian Name ____________________________
Parent/Guardian Signature ____________________________ Date __________

Parent/Guardian Name ____________________________
Parent/Guardian Signature ____________________________ Date __________