

**“Sea Camp of Oregon” August 16-19, 2009**

**MEDICAL INFORMATION**

***MUST BE COMPLETED AND SIGNED FOR ADMISSION!***

Student’s Name: \_\_\_\_\_ Age: \_\_\_\_\_

Male  Female

**Medical “Consent to Treat” Form**

I hereby give “consent to treat” the above named student for routine medical problems and minor injuries. This consent for treatment is in effect only during the times that this student is attending a **Southern Oregon University Youth Programs** class, camp, or fieldtrip. Furthermore, I understand that in cases of serious injury or emergency, SOU Youth Programs staff will attempt to contact me immediately and will transport my child to the nearest hospital. I also understand that there is no medical or hospitalization insurance provided by the program and that all medical costs are the responsibility of parents/guardians.

\_\_\_\_\_  
**Signature** of Parent/Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
**Print** Name of Parent/Guardian

\_\_\_\_\_  
Next of Kin / Emergency Contact

\_\_\_\_\_  
Address of Parent/Guardian

\_\_\_\_\_  
Address of Next of Kin / Contact

\_\_\_\_\_  
City State ZIP

\_\_\_\_\_  
City State ZIP

\_\_\_\_\_  
Home Phone Work Phone

\_\_\_\_\_  
Home Phone Work Phone

\_\_\_\_\_  
Hospital insurance carrier and policy number

**\*\*\*SEE REVERSE SIDE FOR SPECIAL MEDICAL INSTRUCTION FORM\*\*\***

(OVER)

**SPECIAL MEDICAL INSTRUCTIONS**

Student's name: \_\_\_\_\_ Age: \_\_\_\_\_

**KNOWN ALLERGIES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INSTRUCTIONS PROVIDED BY YOUR DOCTOR ARE NECESSARY IF YOUR CHILD IS TO TAKE PRESCRIPTION MEDICATION.**

TO BE COMPLETED BY PARENT/GUARDIAN:

*In the absence of trained medical personnel, I hereby authorize any person designated by the Program Director to administer or supervise self-administration of the following medication.*

*I agree to send the medication properly labeled with the student's name, name of medication, time to be taken/given, amount of dosage, and doctor's name.*

<u>MEDICATION</u>	<u>DOSE</u>	<u>TIME</u>	<u>DIRECTIONS</u>
-------------------	-------------	-------------	-------------------

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Physician's Phone Number