

KIDS U
MEDICAL AND PHOTO RELEASE INFORMATION

Please complete, sign and return this form on the first day of your Kids U class. Forms may be returned to instructors on the first day of classes.

Student's Name _____ Age _____

Male Female

Student is attending:

Week One (July 13-17)_____ Week Two (July 20-24)_____

Week Three (July 27-July 31)_____ Week Four (August 3-7)_____

PHOTO RELEASE

During KIDS U we take photos and videos for use in our promotional material. Do we have your permission to publish photographs of your child? Please NOTE: We do not publish names of students with any published photographs.

Yes No

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 Pre-College Youth Programs** class or fieldtrip. Furthermore, I understand that in cases of serious injury or emergency, SOU Pre-College 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>
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Signature of Parent/Guardian

Date signed

Name of Physician

Physician's Phone Number