

**KIDS U**  
**MEDICAL AND PHOTO RELEASE INFORMATION**

Please complete, sign and return this form on the first day of your Kids U class. Forms can be turned into instructors.

Student's Name \_\_\_\_\_ Age \_\_\_\_\_

Male  Female

**Student is attending:**

Week One (July 14-18)\_\_\_\_\_ Week Two (July 21-25)\_\_\_\_\_

Week Three (July 28-August 1)\_\_\_\_\_ Week Four (August 4-8)\_\_\_\_\_

**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 Please NOTE: We do not publish names of students with any published photographs.*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