Youth Program Medical Information Form

Participant Name: _____ **Age:**_____

Program/Activity Name: _____**Program Date:**_____

Instructions

The University of Alabama requests the information on this form so that, in case of emergency, we will have accurate information to assist with providing or securing appropriate medical assistance for our participants. It is recommended that you consult with a physician prior to participating in this program. If the participant has a pre-existing medical condition, participation in any strenuous activity may not be recommended. You are accountable for providing an accurate medical history, but final determination about appropriateness of participation is the responsibility of you and your physician.

Please answer all questions below. If the participant has any medical issue that is not specifically requested below, but which you think is important, please include that information in Section IV. If you answer yes to any of the following, please explain as indicated.

Parent/Guardian Information

Name of Parent/Legal Guardian: _____

Address: _____

City: _____State: _____Zip: _____

Primary Phone Number: _____Alternate Phone Number: _____

Emergency Contact Information

Primary Person to notify in case of emergency:_____Relationship:_____

Contact's Phone Number(s): (____) _____, (____) _____

Secondary Person to notify in case of emergency:_____Relationship:_____

Contact's Phone Number(s): (____) _____, (____) _____

Family Physician:_____Phone Number: (____) _____

Insurance Provider:_____Phone Number: (____) _____

Insurance subscriber name: _____Subscriber date of birth: _____

Policy Number: _____

(Please attach a copy of the front and back of your insurance card with this form.)

I understand that The University of Alabama does not offer any form of health, liability, or other insurance coverage for participants. (Please initial: _____)

Medical Information

Are all immunizations up to date?____Yes ____ No Date of last tetanus shot:_____

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Please list any current medical concerns or medical history we need to know about your child: (Ex. past injuries, current conditions, physical limitations, etc.) _____

_____

If your child has any limiting medical conditions that you or your doctor feel could impact participation in this program, please explain. _____

_____

List any allergies: (Ex. medications, bee stings, food, latex, plants, etc.)_____

_____

Explain any accommodations that your child needs to enable them to safely participate in the program/activity: (Attach additional information, if necessary.)_____

_____

_____

Additional Information

Please provide any additional information or explanation that you feel could be relevant or beneficial for our staff to know in supporting your child during this program. (Attach additional information, if necessary.)

_____

_____

_____

Authorization for Medical Care

I understand that my child is voluntarily participating in a program/activity at The University of Alabama. By signing this form, I hereby acknowledge that all information is accurate and current, that any activity restrictions, allergies, and medications are listed on this form, and to the best of my knowledge, my child is capable of participating safely in this program/activity. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program/activity. I agree to notify the program/activity of any changes in my child's mental, physical, or medical condition before the program/activity begins.

In the case of accident or illness, I hereby authorize the program/activity staff to administer or seek medical treatment for my child, as they see fit, including routine first aid care or emergency medical treatment. I will assume the financial responsibility for any costs associated with health care for my child that may occur during this program. I hold harmless and agree to indemnify the program/activity, The University of Alabama, its agents, and the Board of Trustees from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment. I acknowledge that I am solely responsible for any hospital or other costs arising out of any bodily injury or property damage sustained through my child's participation in such voluntary program/activity.

Signature of Parent/Guardian:_____ Date:_____

Parent/Guardian Name:_____