Appendix A

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

PROGRAM/CAMP INFORMATION

Program/Camp Name _____ (hereafter "Program")

Date(s): _____ Time(s): _____

Location: _____

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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 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:

Home Phone Work Phone Cell Phone Relationship

_____

Emergency Contact #2:

Home Phone Work Phone Cell Phone Relationship

_____

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 his/her 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