# West Virginia University

**Protection Children WVU Programming**

**Consent for Treatment/Immunizations of a Minor**

FOR UNIVERSITY HEALTH SERVICES USE ONLY

Patient Name: Medical Record #: DOB: Gender: Provider: Date:

*This form must be completed and returned to the camp director prior to the program start date.*

## Personal Information

Camper’s Last Name

First Name Birthdate

M☐ F ☐

Specify program your child will attend

Address

City

State

Zip

Home Phone Parent/Guardian 1 Parent/Guardian 2 Health Insurance Carrier

E-mail Address Daytime Phone Place of employment Daytime Phone Place of employment Policy Number Plan Number

Is physician authorization needed? ☐ Yes ☐ No Family Physician

### In case of emergency, please notify the following individual(s) if neither parent nor guardian is available:

1. \_ Phone
2. \_ Phone

Phone

## Health History

Allergies: Date of most recent tetanus immunization:

Please list any *major* past illnesses (contagious and non-contagious): Please list any *major* operations or serious injuries (include dates): Has the camper ever been hospitalized? ☐ No ☐ Yes

Does the camper have a chronic or recurring illness? ☐ No ☐ Yes

***If YES***, explain: \_

Is there anything else in camper’s health history that the camp staff should know? Are there any activities from which the camper should be restricted? ☐ No ☐ Yes

Does the camper have any special dietary restrictions? ☐ No ☐ Yes

***If YES***, explain: \_

Does the camper wear any medical appliances (glasses, contact lenses, orthodonture, etc.)☐?

***If YES***, explain:

No ☐ Yes

Is the camper’s immunization record current showing that the camper has been immunized in accordance with the West Virginia Bureau for Public Health State Vaccine Requirements? ☐ No ☐ Yes ***If No***, attach official documentation of exemption from immunizations for Reasons of Conscience or a Physician’s Statement of medical contraindications.

This authorizes West Virginia University physicians, medical personnel and camp sponsors to release information concerning the medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information of \_ (participant name) to camp staff. This information includes injuries or illnesses relevant to participation in the above-named camp at West Virginia University.

SIGNATURE OF CAMPER DATE

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

CAMPER’S DATE OF BIRTH PROGRAM NAME

Will the camper need to take any medication at camp? ☐ No ☐Yes

*If YES, please list the specific prescription or over-the-counter medications below, reasons for medication, and daily dosage.*

|  |  |  |
| --- | --- | --- |
| **Medication** | **Reason(s) for Medication** | **Daily Dosage/Time(s) Taken** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

West Virginia University sponsored (camp/program name) designated personnel will not dispense non- prescription or prescription medication to the above-named participant until the following information has been completed by a parent or guardian. It is the responsibility of the parent/guardian to give the medication directly to the camp director or designated staff member in individual dosage containers, original prescriptions containers, or envelopes clearly labeled with dosage instructions on the first day of camp.

I , the parent/guardian of give permission to the staff of the (camp/program name) to administer the prescription medications listed above.

My child may possess and self-administer the following medicine: and I affirm that my child understands and agrees that he/she will use the medication only according to dosage instructions, and will not share or otherwise provide medication to any other person while at camp, and failure to do so is a violation of camp rules that will result in disciplinary action, up to and including removal from camp.

### I hereby release West Virginia University, its Board of Governors, faculty, staff, students, and volunteers from any and all liability in any way resulting or arising from the administering of the above medication.

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

I, the undersigned, as the parent or legal guardian of (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor; and to provide or arrange necessary related transportation for minor to a healthcare facility for emergency services as needed. The attending provider, appropriate staff, and West Virginia University and is faculty, staff, students and volunteers shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and I hereby release them from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and

provided that these services are performed with ordinary care.

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

PRINT NAME

## Please Return to Camp Director:

Name of Program:

Camp Director:

Camp Director Phone: Camp Director Fax:

Camp Director Mailing Address:

To request disability-related accommodations, please contact West Virginia University ADA Coordinator in the WVU Division of Diversity, Equity

and Inclusion at 304-293-5600 (Phone), 304-293-8279 (Fax), or e-mail at [Diversity@mail.wvu.edu.](mailto:Diversity@mail.wvu.edu) More information is available at https://diversity.wvu.edu/

***Origination: 5/6/2020***

***Next Review: 2/2023***