FORM B

MEDICAL INFORMATION AND MEDICAL TREATMENT RELEASE AND AUTHORIZATION FORM

Program Information

Program Name: ________________________________

Date(s): ______________________________________

Location(s): ___________________________________

[Note: The program information should be filled in by the Program Director]

Participant Information

Participant Name: _____________________________

Address:______________________________________

City, State, Zip Code: ___________________________

Date of Birth: _________________________________

Gender: ______________________________________

Medical Information

The decision whether to permit the participant identified above ("Participant") to participate in the program identified above ("Program") is the sole responsibility of Participant, his/her parent(s) or legal guardian(s), and/or his/her physician(s). The following information will not be used by The University of Tennessee to determine Participant's ability to participate safely in the Program.

Participant's Primary Care Physician's Name and Phone Number: ______________________________

Date of Participant's most recent tetanus toxoid immunization: ________________________________

For the following questions, please circle a response and explain as appropriate:

Question	Response
Does participant have any limiting medical conditions that Participant, you, and/or Participant's doctor believe may limit Program participation? If "yes," please identify the condition and explain its limiting effect: (use the back of this form or a separate sheet if necessary)	YES NO
Is Participant currently taking any medication that Participant, you, and/or Participant's doctor believe may interfere with his/her ability to participate safely or effectively in the Program? If "yes," please identify the medication and explain its potential effect: (use the back of this form or a separate sheet if necessary)	YES NO
Does Participant have a history of allergies or reactions to medications, insect stings, plants, or foods? If "yes," please explain the history: (use the back of this form or a separate sheet if necessary)	YES NO
Does Participant have a history of, or currently suffer from, any other medical condition(s) of which the Program staff needs to be aware? If "yes," please identify the medical condition(s) and explain what the Program staff needs to know:(use the back of this form or a separate sheet if necessary)	YES NO

MEDICAL INFORMATION AND MEDICAL TREATMENT RELEASE AND AUTHORIZATION FORM (PAGE 2)

Medical Insurance Information

Policy holder's name: ______________________________

Policy holder's relationship to Participant: ______________________________

Policy holder's address: ______________________________

Please either attach a photocopy of both sides of your insurance card (preferred) or provide the information requested here:

Insurance company name and address: ______________________________

Insurance company phone number: ______________________________

Policy numbers: ______________________________

Emergency Contact Information

Name of Participant's Emergency Contact: ______________________________

Daytime telephone number: ______________________________

Evening telephone number: ______________________________

Relationship to Participant: ______________________________

Authorization for Medical Treatment

In the event of an accident or serious injury or illness, I hereby authorize The University of Tennessee and its trustees, officers, employees, agents, and volunteers in official and individual capacities ("Releasees") to obtain medical treatment for Participant. I further agree to accept full responsibility for any and all expenses, including but not limited to medical expenses, that result from, arise out of, or are related to any injuries to my Child that may occur during his/her participation in the Program, Participant's travel to or from the Program, or Participant's presence on premises owned, leased, or operated by Releasees, INCLUDING BUT NOT LIMITED TO INJURIES SUSTAINED AS A RESULT OF THE NEGLIGENCE OF RELEASEES.

As Participant's parent or legal guardian, I understand and acknowledge that my failure to disclose relevant information may result in harm to Participant and/or others during this Program. By signing my name I represent and warrant that I have provided all material information to The University of Tennessee pertaining to the medical condition(s)identified above and that it is accurate and complete. I agree to notify The University of Tennessee in writing of any changes in the medical condition of the Participant prior to the start of the Program.

I understand that my disclosure of the medical information above will not be used by The University of Tennessee to determine Participant's ability to participate safely in the Program. I understand that, if Participant participates in the Program, he/she does so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of Participant, me, and/or his/her physician(s).

Signature of Participant's Parent or Legal Guardian: ______________________________

Printed Name of Participant's Parent or Legal Guardian: ______________________________

Date: ______________________________

FORM B1

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Program Information

Program Name: ________________________________

Date(s): ______________________________________

Location(s): ___________________________________

[Note: The program information should be filled in by the Program Director]

Participant Information

Participant Name: ______________________________

Address: ______________________________________

City, State, Zip Code: ___________________________

Date of Birth: __________________________________

Gender: _______________________________________

This form must be completed fully in order for the participant identified above ("Participant") to self-administer prescription medication during the program identified above ("Program"). A separate form must be completed for each medication to be administered. Self-administration of medication requires the written authorizations (below) of a licensed health care professional and Participant's parent or legal guardian.

☐ No, my child does not need to take any prescription medication during the Program.

☐ Yes, my child will need to take a prescription medication during the Program.

All prescription medications, including medications for conditions such as food, drug, or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that Participant can self-manage care and delivery of medication. Prescription medication must be in its original container labeled with the minor's name, medication name, dosage, and time/frequency of administration.

AUTHORIZATION FROM PRESCRIBER FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication name: ____

Dosages: ______________________ ______________________________

Condition(s) for which medication is being administered: ____________________

Specific directions (e.g., on empty stomach, with water): ____________________

Time/frequency of administration: ______________________________

If PRN, frequency: ____

If PRN, for what symptom(s): ___________________________________

Relevant side effect(s): ______________________________________

Medication shall be administered from ____________________ to ____________________

Special storage requirements: __________________________________

Is Participant capable of self-managed care: _______________________

I hereby affirm that Participant has been instructed in the proper self-administration of the above-described medication.

Prescriber's name: ____

Prescriber's signature: _______________________________________

Date: ____

I hereby authorize and recommend Participant to self-administer the above-described medication. I also affirm that Participant has been instructed in the proper self-administration of the above-described medication by his/her physician.

Signature of Participant's Parent or Legal Guardian: ___________________________

Printed Name of Participant's Parent or Legal Guardian: ________________________

Date: ____

FORM B2

AUTHORIZATION FOR DISPENSATION OF OVER-THE-COUNTER MEDICATION

Program Information

Program Name: ________________________________

Date(s): ______________________________________

Location(s): __________________________________

[Note: The program information should be filled in by the Program Director]

Participant Information

Participant Name: ____________________________

Address: _____________________________________

City, State, Zip Code: _________________________

Date of Birth: _________________________________

Gender: ______________________________________

Over-the-counter medication ("OTC medication") may at times need to be dispensed to a participant in the above-described program if approved by the participant's parent or legal guardian. Please complete this form to save time if you choose to authorize Program staff to offer OTC mediation to the participant described above ("Participant") during the Program. **NOTE: The University of Tennessee will not dispense any OTC medication without the written authorization of a participant's parent or legal guardian.**

I authorize Program staff to offer the following medications to Participant if the need arises, in the sole judgment of the staff of the Program, as directed on the manufacturer's container (check the blanks below for each OTC medication(s) you authorize):

___________ Ointments for minor wound care, first aid as directed (e.g., antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
___________ Tylenol/Acetaminophen
___________ Ibuprofen
___________ Throat lozenges and/or spray for a sore throat
___________ Micatin or other anti-fungus treatment for athlete's foot
___________ Kaopectate or Imodium for diarrhea
___________ Milk of Magnesia, Pepto Bismol, or Mylanta for upset stomach or nausea
___________ Rolaids or Tums for acid reflux, heartburn, or indigestion
___________ Benadryl for swelling, hives, or allergic reaction
___________ Actifed or Sudafed for nasal congestion or allergy relief
___________ Visine or other eye drops for minor eye irritation
___________ Medicated lip ointment for dry, chapped lips, lip blisters, or canker sores
___________ Swimmer's ear drops
___________ Hydrocortisone ointment for mild skin irritations, poison ivy, or insect bites
___________ Medicated powder for skin irritation
___________ Robitussin or other cough syrup
___________ Calamine lotion for bug bites and poison ivy
___________ Sunscreen
___________ Insect repellant
___________ Other (list any other approved OTC medications): ________________________________

Program staff reserves the right to use generic equivalents when available for the name brand OTC medications identified above.

If Participant is allergic to any type of OTC medication, please identify the OTC medication(s):

____

Program staff will contact Participant's emergency contact if Participant has any condition associated with fever.

I hereby authorize the dispensation of OTC medications to Participant as indicated above. I understand that such dispensation will not be done under the supervision of medical personnel. I understand that the OTC medications indicated above are not necessarily kept on hand and may not be available to be dispensed immediately.

Signature of Participant's Parent or Legal Guardian: ______________________________

Printed Name of Participant's Parent or Legal Guardian: ___________________________

Date: ____