Camper/Student Health Form

This form should be completed and signed by the student's parent/legal guardian if the student is under 18 and physician.

STUDENT INFORMATION

Last Name	First Name	Middle Initial

Home Address

City	State	Zip

MEDICAL INFORMATION

Allergies:

☐ No known allergies

☐ Student/camper is allergic to:

☐Food ☐Medicine ☐ Environmental (insect stings, hay fever, etc) ☐Other

Please describe what the camper/student is allergic to and the reaction seen.

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:	**Backup contact:**
Name _____	Name _____
Relation _____	Relation _____
Cell Phone _____	Cell Phone _____

WHAT ELSE SHOULD WE KNOW? Please provide any additional information that would be helpful for the staff to know for your student/camper to have a successful time while here.

INSURANCE POLICY INFORMATION

The above-named student is covered by health insurance: **Yes** **No**
If yes, provide the following information

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____

Address _____ Relation _____

City/State/Zip _____ Occupation _____

Insurance Carrier _____

Insurance Carrier Phone number _____

Policy # or Member ID # _____ Plan or Group # _____

- **Attach a photocopy of policyholder's ID card**
- **Attach a copy of student's insurance card**

IN CASE OF INJURY OR ILLNESS, I HEREBY GRANT PERMISSION TO A HEALTH PROFESSIONAL TO PROVIDE MEDICAL ASSISTANCE AND/OR TREATMENT FOR THE STUDENT NAMED ABOVE. I UNDERSTAND THAT IN CASE OF AN EMERGENCY OR ACCIDENT, 911 WILL BE CALLED. I AUTHORIZE EMERGENCY MEDICAL SERVICES (EMS) TO ADMINISTER ANY MEDICAL TREATMENT, MEDICATION, OR APPLIANCE DEEMED NECESSARY BY EMS. I ALSO AUTHORIZE TRANSPORTATION BY EMS TO THE NEAREST APPROPRIATE MEDICAL FACILITY, IF DETERMINED NECESSARY. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF ALL EMS, HOSPITAL, AND PHYSICIAN CHARGES FOR EMERGENCY SERVICES TO THE STUDENT. I ALSO UNDERSTAND AND ACCEPT FINANCIAL RESPONSIBILITY FOR ANY OTHER MEDICAL EXPENSES INCURRED BY THIS STUDENT DURING ATTENDANCE AT THE PROGRAM.

Parent/Guardian Signature (if under 18) Date

Student Signature (if 18 or older) Date

Please complete Page 3 if the student/camper requires any medication while attending the camp/program, including, but not limited to, inhalers and epi-pens. A physician's signature is required for all prescription medication, inhalers, and epi-pens.

STUDENT NAME _____

GUIDELINES FOR MEDICATIONS AND AUTHORIZATION FOR ADMINISTRATION OF MEDICATION:

All medications will be kept and self-administered by the student. We ask that you list all medications below, including Epi-pens and inhalers, in the instance that we need to provide this information to a medical professional during an emergency. Please list all **prescription and non-prescription/over-the-counter drugs** below, including all dosing information. Please attach an additional sheet if necessary.

Medication	Dosage	Frequency	Indication

Has the student had a reaction to any of these medications? ☐ Yes ☐ No If Yes, which one?
Please describe reaction:

I give permission for the student named above to take the above listed medication for illness or health problems while attending the program (Medication must be provided by the student's/camper's family. University of Denver staff will not be responsible for administering medicate to student/camper or monitoring student's use.)

Please initial _____

AUTHORIZATION FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION:
I understand I must provide all medications listed above. Prescription medications must come in an original pharmacy labeled container with student's name, name of medicine, time medicine is to be given, dosage, date and licensed healthcare provider's name. Over the counter medications must be labeled with student's name and packaged in original container. Dosage must match the signed licensed healthcare provider's authorization. I have discussed the risks related to the use of the medications and understand that I (and my child) acknowledge, accept and assume those risks associated with this use of medication. I have read and understand the conditions set forth above.

SIGNATURE OF STUDENT_____Date_____
(For students 18 years old and older)

SIGNATURE OF PARENT/GUARDIAN:_____Date_____
(Parent/guardian signature required for students under 18 years of age)