LOYOLA UNIVERSITY NEW ORLEANS
NON-RESIDENTIAL SUMMER CAMPS – MEDICAL INFORMATION & RELEASE

Camp/Program Name: _____ Date(s): _____

Loyola University New Orleans requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment for the Participant. You are accountable for providing an accurate medical history. **Final determination about whether to participate is the responsibility of you and your physician.** If the Participant has any medical issue that is not named below but which you think is important, please include that information.

As a Participant, Parent or Guardian I understand that the information requested on this form is intended to help inform Program staff of any pre-existing medical conditions. If the Participant has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. ***This information will be kept in strict confidence and will only be shared with your permission.***

I understand that Loyola University does not offer any form of insurance for the Participant while participating in Program.

PART 1. GENERAL INFORMATION

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.

Participant Name_____

Parent/Legal Guardian Name_____

Street Address_____

City_____ State_____ Zip_____

Home Phone_____ Mobile Phone_____

Date of Birth _____/_____/_____ Gender _____

Please list two emergency contacts (please print):

_____	_____	_____	_____
Emergency Contact Name 1	Mobile Phone	Alternate Phone	Relation to Participant
_____	_____	_____	_____
Emergency Contact Name 2	Mobile Phone	Alternate Phone	Relation to Participant

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PART 2. MEDICAL INFORMATION

It is recommended that the Participant 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.***

Physician's Name _____ Phone Number _____

Date of most recent tetanus toxoid immunization _____/_____/_____

Does the Participant have health insurance? _____YES _____NO

Please indicate policy number, name and address of insurance company. **PLEASE ENCLOSE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD WITH THIS FORM**

Company Name / Policy # _____

Address _____

For the following, circle appropriate response and explain as appropriate:
Does the participant have any limiting medical conditions that you or your doctor feel would limit camp participation?

YES **NO** If yes, identify and explain:

Is the participant currently taking medication that may interfere with ability to safely participate in Program?

YES **NO** If yes, please indicate the medication and the condition being treated:

Does the participant have a history of allergies or reactions to medications, insect stings, or plants?

YES **NO** If yes, please explain:

Does the participant have a history of, or currently suffer from, medical condition(s) of which we need to be aware?

YES **NO** If yes, please explain:

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Does the participant have any other medical issues that you believe we need to be aware of?

YES **NO** If yes, please explain:

PART 3: AUTHORIZATION FOR MEDICAL CARE

Medical needs, with the exception of minor first aid treatment, will be handled through local Emergency Medical Services. Program staff may administer minor first aid treatment. In cases where medical attention is necessary, the Parent or Guardian will be contacted for approval when possible. However, before medical treatment can be provided, we are required to have a medical release signed by the parent/guardian. Hospitals will not perform services unless this form is presented at the time of treatment.

The Participant has my permission to receive medical attention in the event of illness or medical emergency while participating in this Program. I will assume the financial responsibility for any cost of health care for my child that may occur during this Program.

As a Participant, Parent, or Guardian I understand and acknowledge that my failure to disclose relevant information may result in harm to the Participant and/or others during this Program. By signing my name I represent and warrant that I have provided all materials and important information to Loyola University pertaining to the Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify Loyola University of any changes in the Participant's mental, physical or medical condition.

Loyola University will **NOT** use the medical information disclosed above to determine the Participant's ability to participate safely in activities. I understand that, if the Participant chooses to participate in activities, he/she does so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of myself and the Participant.

I have legal authority to consent to medical treatment for the Participant named above.

Participant Name _____ **Parent/Guardian Name** _____

Participant Signature _____ **Date** _____

Parent/Guardian Signature_____ **Date** _____