COLUMBUS STATE UNIVERSITY

EMERGENCY CONTACT, MEDICAL INFORMATION AND AUTHORIZATION FOR MEDICAL CARE

Program Name: _____

Date(s) of Program: _____

Participate Name: _____

Date of Birth: _____ Participant Gender: _____

Parent/Guardian Name: _____ Phone Number: _____

Emergency Contact Information:

Emergency Contact Name: _____ Phone Number: _____

Relationship to Participant: _____

Backup Emergency Contact Name: _____ Phone Number: _____

Relationship to Participant: _____

Health Insurance Information (if applicable):

Insurance Provider: _____ Insurance Phone Number: _____

Policy Number: _____

Physicians/Pediatrician Practice: _____ Phone Number: _____

(Note: Columbus State University does not offer any form of health, liability, or other types of insurance for participants. If available, please attach a copy of the front and back of your insurance card with this form.)

Medical Information:

1. Medical information we need to know about Participant (current conditions, physical limitations, past injuries, etc.): _____
   _____
   _____

   Allergies (medications, stings, foods, iodine, latex, etc.): _____
   _____
   _____

   Medications Participant is currently taking, dosage, and times taken: _____
   _____
   _____

2. Date of last Tetanus shot: _____

3. Does your child need any accommodations to safely participate in the program? _____

   If yes, please explain: _____
   _____

CSU Administration of Medication

CSU faculty, staff and volunteers are not equipped to administer medications to Participants. All participants should be able to administer their own medications.

Authorization for Medical Treatment

I consent to medical and/or surgical care as may become necessary for the Participant's well-being, should the need arise, and I understand that I will be solely responsible for the cost. I authorize Columbus State University to communicate in emergencies with the person(s) identified in my submission materials. I hold harmless and agree to indemnify Columbus State University from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment.

By signing this form, I agree that all information is accurate and current, that all important information is listed on this form, and to the best of my knowledge, my child is capable of participating safely in the Program. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program. I agree to notify the program of any changes in the above information as soon as possible.

Signature of Parent/Guardian: _____

Parent/Guardian Name: _____

Date: _____