BOSTON COLLEGE

Medication & Emergency Treatment Authorization
For Participants in Programs Involving Minors

This form must be completed by a parent or legal guardian prior to participation in any youth program sponsored by Boston College.

I. General Information Concerning Child

Name of Child: _____ **Date of Birth:** ____/____/_____
(Print Last, First, Middle) (MM/DD/YYYY)

Address: _____

_____ **M or F** (circle one)

Name of Boston College Program (the "Program") in which child will participate:

_____

II. Parent or Guardian Information:

Name of Responsible Parent/Guardian: _____
(Print Last, First, Middle)

Home Address (if different): _____

_____

Work address: _____

_____

Home Phone: (_____) ____ - _____ Business Phone: (_____) ____ - _____

Mobile Phone: (____) ____ - _____

III. Emergency Contact Information:

Name of Emergency Contact: _____
(Print Last, First, Middle)

Relation to Child: _____

Home Address: _____

_____

Work address: _____

_____

Home Phone: (_____) ____ - _____ Business Phone: (_____) ____ - _____

Mobile Phone: (____) ____ - _____

IV. Health Insurance Information:

Health Insurance Company: _____

Policy Identification Number: _____

PLEASE ATTACH PHOTOCOPY OF INSURANCE CARD (BOTH SIDES)

V. Health Information

A. Allergies. Is your child allergic to any of the following?

Medications: Yes/No (circle): If yes please explain: _____
_____
_____

Food: Yes/No (circle): If yes please explain: _____
_____
_____

Insect Bites: Yes/No (circle): If yes please explain: _____
_____
_____

B. Medications:
Please List all medications your child is currently taking, including epi-pen, inhaler or insulin injection (add separate sheet if needed):

Medication	Dose	Frequency	Reason
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

PLEASE NOTE: The Program staff prefers whenever possible that medication be administered outside of Program hours, under the supervision of a parent or guardian. If medications need to be administered during program hours, please sign the appropriate authorization below:

☐ **I hereby authorize Program staff to administer to my child the following medication(s):**
_____. I understand that medications must be delivered to the program staff in original containers bearing the name of my child, the prescribing doctor, directions for use, and showing the number of tablets or capsules, as appropriate. No medication will be accepted in bags separate from the original container. I acknowledge that the medication will be administered by a supervisor who is not a licensed health care professional.

Name of Parent or Guardian: _____
(Print Last, First, Middle)

Signature: _____

Date: _____

☐ **I hereby authorize my child to self-administer his or her epi-pen, inhaler, or insulin when he or she requires it during program hours.**

Name of Parent or Guardian: _____
(Print Last, First, Middle)

Signature: _____

Date: _____

C. History:

Please list all significant past or current medical surgical or mental health conditions, including hospitalizations:

VI. Photography

By signing, I give Boston College Campus Recreation permission to record my image, likeness, and/or voice for use in its print and internet publications or productions, including advertising, signage and promotional materials. I also give Campus Recreation permission to use my name, academic class standing and major in any accompanying caption, if applicable. I agree that the photographs and videos are the property of Campus Recreation and hereby release Campus Recreation from any and all claims that I may have from its use of my image or voice.

Signature of Parent or Guardian: _____

Name: _____
(Print Last, First, Middle)

Date: _____

VII. Consent and Release

I understand that participation by my child in the Boston College program named above involves a certain degree of risk. I also understand that participation in the Program is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

In case of an emergency involving my child, I understand that effort will be made to contact me or the individual listed as the emergency contact person.

In the event that neither me nor the emergency contact person can be reached, permission is hereby given to the medical provider selected by those in charge of the Program to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Medical providers are authorized to disclose protected health information to the supervisors of the Program, and/or any physician or health care provider involved in providing medical care to my child, including examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the me, and/or determination of my child's ability to continue in the Program activities.

I have carefully considered the risk involved and give consent for my child to participate in these activities. I approve the sharing of the information on this form with program administrators and professionals who need to know of medical situations that might require special consideration for the safety of my child.

I release the Boston College, its employees and volunteers, including, without limitation, those persons having responsibility for the Program from any and all claims or liability arising out of this participation.

Signature of Parent or Guardian: _____

Name: _____
(Print Last, First, Middle)

Date: _____