GEORGIA STATE UNIVERSITY

EMERGENCY CONTACT, MEDICAL INFORMATION AND AUTHORIZATION FOR MEDICAL CARE

Program Name: ____

Date(s) of Program: ____

Participant Name: ______________________________ **Date of Birth:** __________________

Parent/Guardian Name: ______________________________ **Phone Number:** ______________

Emergency Contact Information

Emergency contact name and phone number: ______________________________

Relationship to Participant: ____

Backup emergency contact name and phone number: __________________________

Relationship to Participant: ____

Health Insurance Information (if available)

Insurance Provider: __________________________ **Insurance Phone Number:** _____________

Policy Number: ____

Physician/Pediatrician Practice: __________________________ **Phone Number:** ______________

(Note: Georgia 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 your child (current conditions, physical limitations, past injuries, etc.):

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

3. Medications child is currently taking, dosage, and times taken:

4. Does your child need any accommodations to safely participate in the program? If yes, please explain.

Authorization for Program Staff to Administer Medication (if applicable)

Medication: ____

Dosage: ____

Instructions (when to give, whether to take with food, etc.): ______________________

Special Storage Instructions: ______________________________________

I authorize the Program staff to administer my child the above-listed medication. I understand that medication, whether over-the-counter or prescription, must be kept in original containers with original label. When no longer needed, medications shall be returned to me whenever possible. If the medication cannot be returned, it shall be destroyed.

Authorization for Medical Treatment and Information Disclosure

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 the cost. I authorize the University to communicate in emergencies with the person(s) identified in my submission materials. I hold harmless and agree to indemnify the University from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment.

If Participant or a Participant family member shows symptoms of COVID-19 or tests positive for COVID-19, I agree that this information may be shared with appropriate health authorities and health care providers to minimize spread.

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: ______________________________________

Date: ____