WestVirginiaUniversity.
DIVISION OF CAMPUS ENGAGEMENT
AND COMPLIANCE

MEDICAL INFORMATION AND TREATMENT AUTHORIZATION

Youth Program: _____

Date: _____

Location: _____

PARTICIPANT INFORMATION

Name: _____

Home Address: _____

Sex: _____ Birth Date: _____ / _____ / _____ Age at Event: _____

Custodial Parent/Guardian: _____

Home Address (if different from above):_____

Home Phone: _____ Cell Phone: _____ Other: _____

EMERGENCY CONTACT INFORMATION

Name 1: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Name 2: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Other: _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, name of insurance company: _____ Group #:_____

Name on Insurance Card: _____ Phone: _____

PHYSICIAN INFORMATION

Physician's Name: _____ Phone: _____

ALLERGY INFORMATION

Do you have any allergies? ☐ Yes ☐ No

If yes, do you carry epinephrine, such as an Epi-Pen? ☐ Yes ☐ No

If yes, have you ever been hospitalized for these allergies? ☐ Yes ☐ No

Describe your allergies, including severity and other pertinent information: _____

_____

_____

MEDICATION INFORMATION

Medication can only be dispensed from its original container. Ziploc bags, other bottles, bottles printed with someone else's name or any other type of container besides the original will not be accepted. Medication must be clearly labeled with the participant's name, medication name, dosage and instructions. Medications must and will be administered according to the actual dosage listed on the bottle, unless there is a written note from the prescribing physician outlining different instructions for the administration of medications.

Revised: 03/01/2025
Next Review: Spring 2028

My child will be taking medications during this event: ☐Yes ☐ No

Name of medication	Date started	Reason for taking	When to give	Amount to give	How to give

I give permission for common over-the-counter (non-prescription) medication and health care items to be administered to my child as needed to manage illness and injury: ☐ Yes ☐ No

OTHER PERTINENT HEALTH INFORMATION

Does your child have any mental health needs that may interfere with them fully participating in this event?

_____

Is there any additional information about your child's health that you think is important or that may impact their ability to participate in this event?

_____

_____

ACCURACY STATEMENT

I understand that while all reasonable efforts will be made to provide a safe environment, certain risks are involved. In consideration for the opportunity to participate in the activity, I understand the state of West Virginia, West Virginia University, its Board of Governors, officers, employees, agents and volunteers are not liable in case of accidental injury or illness. I hereby further understand that in case of serious injury or illness, I will be notified. If it is impossible to contact me, I hereby give permission for emergency treatment or surgery as the attending physician recommends.

This health form is correct and complete as far as I know, and the person herein described has permission to engage in all event activities except as noted. I hereby give permission to the event to provide routine health care, administer prescribed medications and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the event to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the event to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of the event.

_____

Parent/Legal Guardian's Signature Date