Penn State University Youth Program Health Services Medical Treatment Authorization

This form must be completed and returned before youth camp/program/event enrollment dates in order for youth to be permitted to participate in any camp activities.

Personal Information

Youth's Last Name _____ First Name _____ Birthdate _____ ❑ M ❑ F

Specify camp your child will be attending _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ E-mail Address _____

Parent/Guardian #1 _____ Parent/Guardian #2 _____

Daytime Phone _____ Daytime Phone _____

Place of employment _____ Place of employment _____

Health Insurance Carrier _____ Policy Number _____

Plan Number _____ Is physician authorization needed? ❑ Yes ❑ No

Name of Family Physician _____ Phone _____

In case of emergency, please notify

If neither parent or guardian is available in an emergency, please contact:

1. _____ Phone _____
2. _____ Phone _____

Health History [Please check and provide approximate dates that camper suffered from allergies and other conditions listed below]

Allergies

❑ Hay Fever ❑ Bee/Wasp Stings ❑ Insect Stings ❑ Penicillin ❑ Peanut ❑ Other Food/Drugs: _____

Other

❑ Asthma ❑ Diabetes ❑ Convulsions ❑ Concussion ❑ Behavioral/Emotional ❑ Other: _____

Date of most recent tetanus immunization: _____

Please list any ***major*** past illnesses (contagious and non-contagious): _____

Please list any ***major*** operations or serious injuries (include dates): _____

Has the youth ever been hospitalized? _____

Does the youth have any chronic or recurring illness? _____

Is there anything else in youth's health history that the camp staff should know? _____

Are there any activities from which the youth should be restricted? _____

Are there any specific activities that should be encouraged? _____

Does the youth have any special dietary restrictions? ❑ NO ❑ Yes If YES, explain: _____

Does the youth wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? ❑ NO ❑ Yes If YES, explain: _____

Will the youth need to take any medication at camp? ❑ NO ❑ Yes ***If YES, please complete the Youth Camp/Program/Event Medication Form***

I hereby authorize the clinical staff of University Health Services or other licensed practitioner of the healing arts, acting within the scope of his or her practice under State law to provide medical care that includes routine diagnostic procedures (e.g., x-rays, blood and urine tests) and medical treatment as necessary to my minor daughter/ son/dependent. I understand that the consent and authorization herein granted does not include major surgical procedures and are valid only during the youth camp/program/event.

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and if I cannot be reached, I give my consent for physicians and staff at University Health Services or other licensed practitioners of the healing arts to perform any necessary emergency treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. I understand that University Health Services does charge for services and that it is my responsibility to pay the bill. As applicable, I am responsible to submit any claims to my health insurance company for reimbursement. I authorize The Pennsylvania State University to receive medical/billing information and submit it to the University's insurance carrier.

HIPAA

Penn State honors the privacy of the participants in its programs and complies with the national regulations regarding health information. Follow this computer link to the University Health Services Notice of Privacy Practices.

http://studentaffairs.psu.edu/health/welcome/confidentiality/noticeOfPrivacyPractices.shtml)

I understand that, unless specifically stated otherwise in the Penn State youth camp/program/event literature, The Pennsylvania State University does not provide medical insurance to cover emergency care or medical treatment of my child.

_____ _____

Parent's/ legal guardian's name (please print) Signature

* Terms and Conditions agreed to via electronic signature

Date: _____