Participant Registration

Participant Name: _____ Date of Birth: _____

What grade will the participant be in during the Fall21/Spring 22 school year? _____

What school will the participant be attending in the Fall21/Spring 22 school year?

_____

Medical Information

Instructions

The University of Louisville requests the information on this form so we will have accurate information in the event of an emergency. It is recommended that you consult with a physician prior to participating in any program. If the participant has a pre-existing medical condition, participation in any strenuous activity may not be recommended. You are accountable for providing an accurate medical history, but final determination about appropriateness of participation is the responsibility of you and your physician.

Please answer all questions below. If the participant has any medical issue that is not specifically covered below, but which you think is important, please include that under Additional Information.

Parent/Guardian Information

Name of Parent/Legal Guardian: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone Number: _____ Alternate Phone Number: _____
Email: _____

Emergency Contact Information

Primary Contact for Emergencies: _____ Relationship: _____
Contact's Phone Number(s): _____
Secondary Contact for Emergencies: _____ Relationship: _____
Contact's Phone Number(s): _____
Family Physician: _____ Phone Number: _____

Individuals allowed to check-out camper daily

(excluding parent/guardian).
Individuals must show identification (photo ID) before camper is released.

Name:_____ Relationship to Camper: _____

Name:_____ Relationship to Camper: _____

COVID-19

Participants and/or guardians experiencing symptoms of COVID-19 should not report to the camp site/facilities for camp. Participants attending camp must have a means of transportation daily so if they do experience symptoms they can be checked out and leave camp with their parent, guardian or emergency contact.

Insurance Information

If your child is covered by family medical/hospital insurance, please provide the details below. This will assist us in making the appropriate billing arrangements in the event that your child needs medical care. Insurance coverage is not a requirement for participation in the program.

Insurance Provider: _____ Phone Number: _____
Insurance Subscriber Name: _____ Subscriber Date of Birth: _____
Policy Number: _____
I understand that The University of Louisville does not offer any form of health, liability, or other insurance coverage for participants. (Initial: _____)

Immunization History

Although immunizations are not required for participation, we strongly encourage that program participants are appropriately immunized for, at minimum, the following diseases: tetanus, measles, mumps, rubella (MMR), meningococcal meningitis.

By signing below, I acknowledge and accept the following:

Because immunizations are not required, program participants may be exposed to individuals who have not been immunized and/or individuals who may carry infectious diseases, which may result in a program participant contracting an infectious disease. I understand and accept the risks to my child that relate to and arise from potential exposure to and contraction of an infectious disease.

Signature of Parent/Guardian: _____ Date: _____

Medical Concerns

Please list any current medical concerns or medical history we need to know about your child: (Ex. past injuries, current conditions, physical limitations, etc.) _____

_____

_____

List any allergies: (Ex. medications, bee stings, food, latex, plants, etc.) _____

_____

Will your child need to take medication(s) during the program? ____Yes ____No

If Yes, please complete a Medication Management form for each medication, place the completed form(s) with the medication(s) in a Ziplock bag clearly labeled with the participant's name and date of birth, and provide the bag to a program Authorized Adult at check-in. These medications will be secured and provided to the child as described on the Medication Management Form. Please consult with the program director if your child has medication(s) that must stay with them at all times.

Does your child have a need that requires reasonable accommodations to enable them to participate in the program/activity? ____Yes ____No

To request reasonable accommodations, contact the UofL Youth Protection Officer at (502) 852-0210. Requests should be submitted in writing at least 30 days prior to the event. Late requests may not be accommodated due to time constraints.
If accommodations are requested, I give The University of Louisville permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include sharing information with appropriate University personnel, and I acknowledge that such communication is consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. (Initial: _____)

Additional Information:

Please provide any additional information or explanation that you feel could be relevant or beneficial for our staff to know in supporting your child during this program. (Attach additional information, if necessary.)

_____
_____
_____
_____
_____
_____
_____
_____

Authorization for Medical Care

I understand that my child is voluntarily participating in a program at The University of Louisville. By signing this form, I hereby acknowledge that all information is accurate and current, and, to the best of my knowledge, my child is capable of participating safely in this 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 Director of any changes in my child's mental, physical, or medical condition before the program begins.

In the case of accident or illness, I hereby authorize the program/activity staff to administer or seek medical treatment for my child, as they see fit, including routine first aid care or emergency medical treatment. However, I understand and acknowledge that such staff are not medical professionals. I hold harmless and agree to indemnify the program, University of Louisville, The

University of Louisville Board of Trustees, and its agents and employees, from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment or lack thereof. I acknowledge that I am solely responsible for any hospital or other costs arising out of any illness, bodily injury or property damage sustained through my child's participation in such voluntary program.

Preferred Hospital: _____

Signature of Parent/Guardian: _____ Date: _____

Parent/Guardian Name: _____

Will the participant need to take any medications while at Camp?

If yes, please complete section below.

Medication Management Instructions

Prescription or over-the-counter (OTC) medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that the medications will be secured by Authorized Adults and made available to participant for self-administration as authorized in writing by the participant's parent or guardian. It is the participant's responsibility to come to get their medications, but program staff will make every effort to remind them as needed. If the participant is unsure of the medication to take or the correct dosage, program staff will contact the parent or guardian for clarification.

Medication must be in its original container and all labels must be intact with instructions clearly legible. Prescription medications must be labeled by the pharmacist or prescriber, with the name, address and phone number for pharmacist or prescriber. It is advised that containers hold only the amount required for the time the participant will be attending the Program. If a tablet should be cut in half, this should be done before the submitting medication to the Program. Please send medicine cups for liquid medications.

All medications for a single participant should be stored in a plastic Ziplock bag labeled with the participant's name and date of birth. All medications and medication bags will be returned to the participant's parent or guardian when the program is over.

The form below must be completed fully in order for participants to self-administer required prescription or OTC medication. A new Medication Management form is required for each program attended by the participant, each medication, and each time there is a change in dosage or time of administration of a medication.

Note: Unless we have prior parental authorization, we will not provide any OTC medications.

Medication Management

Participant Name: _____ Date of Birth: _____

Program Name: _____ Program Date: _____

Medication Information

Medication Name: _____ Dose: _____
Condition for which medication is being administered: _____

_____

_____

Specific Directions (e.g., on empty stomach/with water, taken with food, etc.): _____

_____

_____

_____

Time/frequency of administration: _____
□ If taken as needed, frequency: _____
□ If taken as needed, for what symptoms: _____
Relevant side effects: _____

_____

_____

Medication shall be administered from (date): _____ to _____
Special Storage Requirements: Is refrigeration required? ___Yes ___No
Medication a Controlled Substance? ___Yes ___No
Prescriber's Name/Title: _____
Prescriber's Place of Employment: _____ Telephone: _____
If your child requires any assistance with their medications, please explain: _____

_____

_____

_____

_____

Authorization

□ I authorize and recommend self-administration by my child for the above medication.
(Initial: _____)
□ I also affirm that my child has been instructed in the proper self-administration of the prescribed medication by their attending physician.
(Initial: _____)
□ I shall indemnify and hold harmless the Program Staff, The University of Louisville, University of Louisville Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child's self-administration of prescribed or OTC medication(s).
(Initial: _____)

Signature of Parent or Guardian: _____ Date: _____
Parent or Guardian Name: _____
Work Phone: _____ Cell Phone: _____