PARTICIPANT'S MEDICAL INFORMATION

Ohio University requests this information so that our Program staff can properly plan to meet the needs of Participant and if there is an emergency, to have accurate information to provide and/or seek treatment for Participant. Participant refers to: (1) if the Participant is 18 years of age or older, it refers only to Participant; or (ii) if the Participant is under the age of 18, Participant refers to the Participant and Participant's parent/guardian. All Participants must have a signed Emergency Medical Consent to participate.

Participant Name/Date of Birth: ____________________
Physician/Address/Phone: ____________________
Dentist/Address/Phone: ____________________

Does the Participant have any illness, special conditions, activity limitations, asthma, allergies (including food), etc. that the Program staff should be aware of? ____Yes ____No
If yes, identify and explain: ____________________

Is the Participant currently taking any medications that we should be aware of including side effects? ____Yes ____No
If yes, identify and explain: ____________________

Is the Participant taking any medications that must be administered during the Program? ____Yes ____No
If yes, you must also complete the *Authorization for Medication Administration form*.

Does the Participant have any relevant medical history that we should be aware of? ____Yes ____No
If yes, identify and explain: ____________________

Does the Participant need any accommodations to safely participate in the Program? ____Yes ____No
If yes, identify and explain: ____________________

Does the Participant have any limitations for attending field trips, if applicable? ____Yes ____No
If yes, identify and explain: ____________________

If the Participant has any additional information or other medical conditions or special needs that you think it is important for Program staff to be aware of, please identify and explain here: ____________________
____
____
____

EMERGENCY MEDICAL CONSENT

To the best of my knowledge the Participant is capable of participating safely in the Program and that any activity restrictions, allergies, and medications are listed on this form. I give permission to Program staff to provide routine first aid care and in the event of serious illness or injury, I give Program staff permission to seek and authorize emergency medical treatment. I give permission for Program staff to perform daily and as needed symptom checks for COVID-19. I hold harmless and agree to indemnify the Program and Ohio University from any claims, causes of action, damages and/or liabilities arising out of or resulting from said medical treatment. I further agree to accept full responsibility for any and all expenses, including medical and transportation expenses that may derive from any injuries that Participant may incur during participation in this Program.

I understand and acknowledge that failure to disclose relevant information may result in harm to Participant and/or others during this Program. By signing my name, I represent that I have provided all materials and important information to the Program pertaining to Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify the Program of any changes before the Program begins.

____
Participant Signature (if age 18 or over)

____
Parent/Guardian Signature (if under 18)