PLEASE BE SURE TO COMPLETE THIS FORM AND SEND WITH THE OTHER TWO FORMS

KIDS IN COLLEGE EMERGENCY FORM

STUDENT NAME _____

HOME ADDRESS _____

**PARENT/GUARDIAN NAME_____

PHONE: HOME _____ WORK _____ CELL_____

PERSONAL PHYSICIAN & PHONE NUMBER_____

INSURANCE COMPANY AND POLICY_____

ANY KNOWN ALLERGIES (FOOD, ETC)_____

DOES STUDENT USE AN INHALER? Yes _____ No _____

In case of emergency, I give my permission to take care of an emergency. ❑ Yes ❑ No

In case of emergency, please contact parent/guardian first. ❑ Yes ❑ No

Primary person to contact if parent/guardian cannot be contacted during an emergency:

NAME: _____ RELATION_____

HOME # _____ WORK # _____ CELL# _____

Secondary person to contact if parent/guardian cannot be contacted during an emergency

NAME: _____ RELATION:_____

HOME # _____ WORK # _____ CELL # _____

The undersigned parent(s)/guardian(s) desire that this child participate in the Kids In College Program and acknowledge and agree that the use of any equipment under supervision of Kids in College staff should be for the benefit of their child. In consideration of the above, I voluntarily assume all risk of an accident, injury, damage of property and release and discharge the State of Ohio, the Ohio University and personnel associated with Kids In College for any injury, illness, or damage arising out of participation in said program.

PARENT SIGNATURE:_____

Please return with Kids In College registration and photo release forms to:

OU-C Kids in College C/O Ann Holmes

Continuing Education

101 University Drive, Chillicothe, Ohio 45601

Or email to OUC-kidsincollege@ohio.edu

If you would like Kids In College personnel to administer medication to your child, please complete the next form.

REQUEST FOR ADMINISTRATION OF MEDICATION

Ohio University-Chillicothe Kids in College

This form is valid for no longer than three weeks: June 10 – 28, 2019. One form must be used for <u>each</u> medication.

<u>Box 1</u> – The following section must <u>always</u> be completed by the parent/guardian.

<u>Check all that apply:</u>

_☐_ Prescription medication
_☐_ Inhaler
_☐_ Epi Pin

<u>Complete all of the following information:</u>

Name of child:_____ Date of birth:_____

Name of medication:_____ Exact dosage:_____

To be administered at the following times:_____

For the following period of time:_____

Parent/Guardian signature:_____

<u>Box 2</u> – The following section must be completed by a licensed physician or nurse practitioner:

_____ is under my care and should receive_____
(name of child) (name of medication)

as follows:_____
(include dosage and instructions)

Possible side effects to watch for are:_____

Expiration date:_____
(may not exceed 12 months from this date of this request for medications)

_____ _____ _____
Signature of physician or nurse practitioner Date of signature Phone number