

MEDICAL CARE AUTHORIZATION
COLORADO STATE UNIVERSITY

Camp or Program Name: _____

Dates: _____ Time(s) _____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. As a camper/ program participant, parent or guardian I understand that:

The information requested on this form is intended to help inform our staff of any pre-existing conditions. If your child has a pre-existing medical condition, participation in any strenuous activities, or recreational time may not be recommended. *This information will be kept in strict confidence and will be shared with your permission.*

Colorado State University (Insert Department Name) _____ requests the information below so that, in the case of an emergency, you have provided us with accurate information about you so that we can provide and/ or seek appropriate treatment. You are accountable for providing an accurate medical history. ***Final determination about whether to participate is the responsibility of you, and your physician.*** If you have any medical issue that is not requested below, but of which you think it is important, please include that information.

PART 1: GENERAL INFORMATION

Name _____ Email Address _____

Parent/ Legal Guardian Name (if applicable) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ / _____ / _____ Gender M/F

PLEASE LIST TWO EMERGENCY CONTACTS:

Emergency Contact #1 Name	Home Phone	Work Phone	Cell Phone	Relation
---------------------------	------------	------------	------------	----------

Emergency Contact #1 Name	Home Phone	Work Phone	Cell Phone	Relation
---------------------------	------------	------------	------------	----------

PART 2: MEDICAL INFORMATION

It is recommended that you consult your physician prior to participating in this camp/ program. If you are uncertain about any preexisting medical conditions, it is your responsibility to consult with your own physician prior to participating in the camp/ program. Please answer all the questions. If you answer yes to any of the following questions, please explain as indicated. Use back and/ or additional paper if needed.

Physician's name _____ Phone Number _____

Most recent tetanus toxoid immunization _____

Do you have health/ accident insurance? Yes/ No

If yes, please indicate policy number, name and address of company. Please include a front and back copy of your insurance card: _____

Do you have any limiting medical conditions that you or your doctor feel would limit your participation in the Camp/ Program?

Yes/ No If yes, identify and explain _____

Are you currently taking medication that may interfere with your ability to safely participate in the camp or the program?

Yes/ No If yes, identify and explain _____

Do you have any allergies or reactions to medications, insect stings or plants?

Yes/ No If yes, please explain _____

Do you have a history, of or do you currently suffer from any medical condition(s) with which we may need to be aware?

Yes/ No If yes, please explain _____

Any other health-related information you think may be important for us to know:

PART 3: AUTHORIZATION FOR MEDICAL CARE

In cases where medical attention is necessary, parents will be contacted for approval when possible. However, we are required to have on file a medical release form signed by the parent/ participant

Camper/ program participant's name _____ has my permission to receive medical attention in the event of illness or medical emergency while participating in this camp or program. I will assume the financial responsibility for any cost of health care for my child/ myself that may occur during this camp/ program.

PLEASE READ: As a participant, parent or guardian I understand and acknowledge that my failure to disclose relevant information may result in harm to myself/ my child and/ or others during this camp/ program. By signing my name I represent and warrant that I have provided all materials and important information to Colorado State University (Department)_____ pertaining to my/ my child's medical, mental and physical condition and that it is accurate and complete. I agree to notify Colorado State University (Department)_____ of any changes to my/ my child's mental, physical or medical condition prior to my/ my child's scheduled camp/program.

By revealing or disclosing the above medical information, it will not be used by Colorado State University personnel or employees to determine my/ my child's ability to participate safely in activities. I understand that, if I/ my child chooses to participate in activities, I/ she/ he do so voluntarily and of my/ his/ her own accord, and the final decision regarding participation is solely the responsibility of myself and my child.

SIGNATURE IS REQUIRED:

Camper/ program participant Name: _____ Date _____

Camper/ program participant's Signature: _____

Parent/ Legal Guardian's Name _____

Parent/ Legal Guardian's Signature _____

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 18.