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BGSU
Bowling Green State University

Participant's Name _____

MEDICAL HISTORY AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

Directions: Parents of minors must complete this form for program staff to provide routine health care and seek emergency medical treatment. Please answer all questions. Please type or print in black ink. Attach any permission forms from your physician to dispense medication to this form. **Incomplete forms will be returned.**

PARTICIPANT INFORMATION

Participant's Name _____ Gender _____
Home Address _____ Date of Birth _____ Age _____
City/State/Zip _____ Home Phone _____
Name of Program Attending _____ From ____ ____ ___ To ____ ____ ____
Overnight ☐ Yes ☐ No

EMERGENCY NOTIFICATION (PARENT OR GUARDIAN)

Before a participant under 18 years of age can be treated, the law requires us to obtain parent/guardian consent for treatment. Accordingly, for the safety and well-being of the participant, please provide us with as many phone numbers as possible.

PRIMARY CONTACT

Name _____
Address _____
Relationship _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

SECONDARY CONTACT

Name _____
Address _____
Relationship _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

PHYSICIAN INFORMATION

Family Physician _____
Address _____
_____
Phone _____

SPECIALIST INFORMATION

Specialist Name _____
Address _____
_____
Phone _____

DENTIST INFORMATION

Family Dentist _____
Address _____
_____
Phone _____

SPORTS CAMPS ONLY:
Date of last physical examination _____ _____ _____
Sport or activity cleared for: _____
List any Restrictions _____

MEDICAL HISTORY – Please indicate if the participant has any chronic childhood conditions or diseases related to the following and list details, including any activity restrictions in the space provided.

- ☐ Arthritis & Rheumatologic Conditions
- ☐ Asthma
- ☐ Bones & Muscles
- ☐ Brain & Nervous System
- ☐ Cancer & Tumors
- ☐ Digestive System
- ☐ Ears, Nose, Throat/Speech, & Hearing
- ☐ Endocrine Glands, Growth, & Diabetes
- ☐ Genetic, Chromosomal, & Metabolic Conditions
- ☐ Heart & Blood Vessels
- ☐ Kidney & Urinary System
- ☐ Learning Disorders
- ☐ Lungs & Respiratory System
- ☐ Sexual & Reproductive System
- ☐ Skin Disorders
- ☐ Sleep Disorders

Details:

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ALLERGIES - ☐ this person has no allergies OR ☐ this person has allergies as follows:

TYPE (Insect, Food, Medications)	DESCRIBE REACTION

MEDICATIONS - ☐ this person takes no medications OR ☐ this person takes medications as follows:

MEDICATIONS	DOSAGE	FREQUENCY	DIAGNOSIS

Note: Our program staff is unable to administer any medications, (prescription or non-prescription) to participants without a signed order by a licensed physician. The Permission to Dispense Medication by Camp Program Staff Form is available for this purpose. Parents or guardians may not send any prescription or over-the-counter medication with a participant that a physician has not signed for.

DISABILITY – Please indicate if participant is handicapped or disabled in any way: ☐ Psychological ☐ Neurological ☐ Hearing ☐ Pulmonary ☐ Learning ☐ Mobility ☐ Other _____

CURRENT MEDICAL CONDITIONS - Please indicate if participant currently has any medical conditions or limitations that do not constitute a handicap or a disability that would impair or limit the participant from fully engaging in the activities of the camp for which the participant is registering, and provide a complete description of such conditions or limitations:

MEDICAL INSURANCE INFORMATION – Is the participant covered by more than one health plan? ☐ Yes ☐ No

Name of Policyholder_____
Policyholder ID # _____
Policyholder Date of Birth _____
Relationship to Participant _____
Policyholder Phone _____
Medical Insurer Name _____
Plan Type _____
Insurer Address _____
_____
Insurer Phone_____
Group Name _____
Group ID # _____

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS AND PRESCRIPTION ID CARD.

Prescription Carrier Name _____
Policyholder same as listed above? _____
Carrier Address _____
_____
Carrier Phone _____
Group Name _____
Group ID # _____

IMMUNIZATIONS
The participant has been immunized in accordance with the recommended immunization schedules for children and adolescents approved by the CDC and The American Academy of Pediatrics ☐ Yes ☐ No. PLEASE NOTE: FOR PARTICIPANTS OF RESIDENTIAL CAMPS, A COMPLETE IMMUNIZATION RECORD IS REQUIRED.

CONSENT FOR MEDICAL TREATMENT

In the event reasonable attempts to contact me are unsuccessful, **PERMISSION** is hereby granted for the examination, treatment and medical care of the participant by the BGSU Student Health Service or another duly licensed healthcare facility. **PERMISSION** is also granted to execute on behalf of the participant any admission or consent forms needed to obtain such treatment. By signing below, I agree that I have read the foregoing and consent to the terms and conditions as stated.

_____ _____ _____
Signature of Parent/Guardian **Print Name** **Date**

STAFF USE:
Form Complete [ ] Yes [ ] No Reviewed by: Action Needed:

University Records Retention Policies recommend that consent forms for minors be kept for a minimum of six years