Parent/Legal Guardian Consent and Release Form for Minor Participants

This release is for _____'s participation in
Name of Minor Participant

_____, hereafter referred to as "the Program."
Program Name

Consent

I have read the Program's Communication and Notification Plan, and I fully understand and consent to the policies and procedures therein.

Authorized Adults

I have authorized the following adults to pick up my minor participant from or drop off my minor participant to the Program in both regular and emergency situations.
I understand that these individuals must be 18 years of age or older and must present a valid photo ID to Program Staff when asked.
I understand that I must provide a signed court order barring custody in order to prohibit release of my minor participant to another parent or legal guardian.

Name of Authorized Adult	Phone Number	Relation

☐ I consent for my minor participant to check themselves in and out of the Program. I understand that the Program's supervisory responsibility of my minor participant only applies in the period of time between check-in and check-out.

Media Release

For valuable consideration herein acknowledged as received, I hereby grant to Virginia Commonwealth University (VCU), its affiliates, legal representatives, and assigns, and those acting with VCU's authority and permission, the irrevocable right and permission to:

1. Record my minor participant's image and/or voice on and/or in a photographic, video, audio, digital, electronic, or any other medium;
2. Use, modify, reproduce, exhibit and/or distribute any such recording, in whole or in part, in any medium now known or hereafter developed in connection with any publication or materials relating to or serving the mission and goals of Virginia Commonwealth University or Virginia Commonwealth University Health System, including advertisements, brochures, other promotional materials, or commercial purposes.
3. Use any such recording with or without my or their name.

I acknowledge and agree that VCU owns all right, title, and interest in and to the recordings, including all copyrights therein. I hereby waive any right I or my minor participant may have to inspect or approve the Images or any finished product or products incorporating the recordings and any written or other print material that may be used in connection therewith, including print material containing my or their name. I acknowledge that nothing in this Agreement obligates VCU or any third party to make any use of the recordings. I release VCU and those acting pursuant to its authority from liability for any violation of a personal or proprietary right I or my minor participant may have in connection with all such recordings and uses.

☐ I consent to the above media release.

☐ I DO NOT consent to the above media release.

Transportation Release

Participation in the Program activities may involve travel or other activities with certain inherent risks that cannot be eliminated regardless of the care taken to avoid them. By my signature below, I hereby give permission for my minor participant to be transported to activities, including participating in walking or vehicular field trips offered by the Program that occur on- or off-campus, should the aforementioned Program require.

Separate from transportation required for Program activities (described above),

☐ I consent for my minor participant to be transported by Program Staff to a hospital or care facility in case of injury.

☐ I DO NOT consent for my minor participant to be transported by Program Staff to a hospital or care facility in case of injury.

Assumption of Risk

(1) I hereby acknowledge that my minor child's participation in the activities described above involves potential risk of personal injury, including the possibility of broken limbs, paralysis or even fatal injury. Nonetheless, being fully aware of the dangers, I desire for my child to participate in such activities and voluntarily assume all risk of loss, damage or injury. Parent/legal guardian initials _____

(2) I understand and agree that Virginia Commonwealth University, its agents, employees, officers, directors and assigns are not responsible for any and all claims, damages, losses, injuries, and expenses arising out of or resulting from my child's participation in these activities. Parent/legal guardian initials _____

(3) I agree that my minor child will act in a reasonable and safe manner while participating in these activities so as not to endanger the lives of persons or property. Parent/legal guardian initials _____

By signing below, I understand that I assume all financial responsibility for damage caused by my minor child's participation in the activities. Furthermore, it is my understanding that Virginia Commonwealth University and their employees assume no liability and further disclaim all responsibility in my voluntary permission of my child's participation in activities.

Signature

I have read and completed this Release Form prior to signing below, and I fully understand the contents, meaning, and legal impact of this consent and release. I understand that I am free to address any specific questions regarding this consent and release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this consent and release. I agree that this Release Form shall remain in effect for the duration of the Program. All participants must have a new Release Form completed each year. If my signature on this form is electronic, I acknowledge that my electronic mark serves as my signature.

_____ _____

Printed Name of Minor Participant | Printed Name of Minor's Parent/Legal Guardian

_____ _____

Signature of Minor's Parent/Legal Guardian | Date

Youth Programs Medical Information and Authorization Form

Minor Participant Full Legal Name: _____
(hereafter "Participant") First Middle Last

Participant Date of Birth (MM/DD/YY): _____ Participant Gender: _____

Participant Home Address: _____

_____

Parent/Legal Guardian Name: _____ Phone Number: (____) _____

Parent/Legal Guardian Name: _____ Phone Number: (____) _____

Emergency Contact Name: _____ Phone Number: (____) _____

Emergency Contact Name: _____ Phone Number: (____) _____

Program Name (hereafter "Program"): _____

Program Date(s): _____

PART 1: MEDICAL INFORMATION

ALLERGIES

Does Participant have any history of allergies or reactions, including, but not limited to, medications, insect stings, or plants? If yes, please explain:

_____

_____

DIETARY RESTRICTIONS

Does Participant have any dietary restrictions?

_____

_____

PHYSICAL/MEDICAL/MENTAL CONDITIONS

Does Participant have a history of, or currently experience, any conditions (asthma, diabetes, cardiac disorders, seizure disorders, ADHD, anxiety, history of heat illness or cramping, etc.) of which the Program would need to be aware? If yes, please explain:

_____

_____

Does Participant require accommodations for any conditions? If so, which accommodations? If requested accommodations include medication, please list any in the tables provided on the final page. Please consider conditions that are temporary or transient such that they may occur during the Program.

_____

_____

INSURANCE INFORMATION (Optional)

I understand that Virginia Commonwealth University does not offer any form of insurance for Participant while participating in Program.

☐ Check here if Participant does not have medical insurance. Medical insurance is **not** a requirement of the program.

If the minor participant does have medical insurance, please provide the below information, or attach a copy of the front and back of the minor participant's insurance card.

Health Insurance Company: _____ Policy Number:_____

Group Number: _____ Effective Date: _____ Termination/Renewal Date:_____

Type: ☐1) POS ☐2) PPO ☐3) HMO ☐4) MEDICAID ☐5) MILITARY ☐6) INTERNATIONAL

Insurance number to call to confirm benefits: _____

Please list any additional medical coverage: _____

_____

Please fill out the below information for the insurance policy holder.

Name & Relationship: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

☐ Check here if your personal health insurance policy is an out-of-state Medicaid policy (not from Virginia).

Part 2: AUTHORIZATION FOR MEDICAL CARE

• I understand, acknowledge, and agree that Virginia Commonwealth University does not provide medical care or medical insurance to cover emergency care or medical treatment of my minor participant.
• I give permission to the Program Staff to give basic first aid treatment to my minor participant if they become hurt/injured during the Program activities. Basic first aid treatment does not include providing medications other than life-saving medication.
• I agree to the release of this medical form to the appropriate medical care provider.
• Virginia Commonwealth University is committed to protecting the sensitive personal information about your minor participant's medical or other conditions. Information will be stored, archived, and disposed of according to the University record retention policies.
• If there is insufficient time to contact me, or the emergency contacts designated on this form, I give permission to the Program Supervisor to consent to the following for my child based on the advice of a licensed health care practitioner acting within the scope of their practice under State law:

☐ Emergency medical treatment

☐ Non-emergency medical care that includes routine diagnostic procedures (e.g., x-rays, blood, and urine tests) and medical treatment.

SIGNATURE

I have read and completed this Authorization for Medical Care prior to signing below, and I fully understand the contents, meaning, and legal impact of this consent and release. I understand that I am free to address any specific questions regarding this consent and release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this consent and release. I agree that this Medical Authorization Agreement shall remain in effect for the duration of the Program. All participants must have a new Medical Authorization Form completed each year.

_____	_____	_____
Parent/Legal Guardian's Name (Please Print)	Parent/Legal Guardian's Signature	Date

Part 3: PARENT/LEGAL GUARDIAN AUTHORIZATION, WAIVER, AND CONSENT FOR SELF-ADMINISTRATION OF MEDICATION

I understand, acknowledge, and agree:

- Program staff will not dispense medications but will monitor the self-administration of certain medications, ONLY upon written consent of the parent(s)/legal guardian(s) or physician's orders.
- That all medications must be stored in the original product packaging and clearly labeled with the minor participant's name and the medication's name and dosage instructions, as well as the prescribing physician's name and telephone number.
- The need for emergency medication may require that a minor participant carry the medication on their person or that it be easily accessed (i.e., inhalers, EpiPens, insulin injections). Program staff or other staff or volunteers affiliated with the Program will NOT purchase medications of any type (prescription or over-the-counter) for minor participants of any age.
- It is NOT permissible for my minor participant to share any medications with any other participants or with Program staff.
- It is the responsibility of the parent(s)/legal guardian(s) to be sure that their minor participant's medications brought to the Program are not left behind at the end of the Program. Failure to do so will result in the medications being destroyed within three working days after the minor participant's last day at the Program. Absolutely no medications will be returned via mail regardless of the circumstance.

Medication Guidelines

Participants may bring prescription or over-the-counter (OTC) medications, including medications for conditions such as food, drug or insect allergies, diabetes, asthma, or

epilepsy to the Program under the condition that the medications will be secured by Program staff and made available to the participant for self-administration as authorized in writing by the participant's parent/legal guardian. If the participant is unsure of the medication to take or the correct dosage, Program staff will contact the parent or legal 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 submitting medication to the Program. Please send medicine cups for liquid medications.

All medications for a single participant should be stored in a plastic zip-lock bag labeled with the participant's name and date of birth. All medications and medication bags will be returned to the participant's parent/legal guardian when the program is over. This form must be completed fully in order for participants to self-administer required prescription or OTC medication.

- All medications must arrive in appropriately labeled and original containers. Medicine in pill boxes or bags is not allowed.
- Medication cannot be shared with others or left unattended.
- It is the responsibility of the participant to come to the designated staff or location at the correct time or onset of symptoms to obtain their medication (as prescribed).
- The designated staff member will log the medication that the participant took.
- The Program is not responsible for missed or incorrect doses. It is not the Program staff member's responsibility to follow up with Participants who do not come to self-administer their own medication.
- Any undisclosed OTC or prescription medication found in a participant's possession will be confiscated. In the event this occurs, Program staff will contact the participant's parent/legal guardian. All medication will be returned to the participant or parent/legal guardian at the end of the day or, if overnight, program.

☐ No, my minor participant does not need to take any medication while at the Program.

☐ Yes, my minor participant will/may need to take medication while at the Program.

Please list all medications on the following tables on the next page and sign below

Part A: Life Saving Medications (ex. EpiPen, inhaler, insulin, etc.)

Medication Name	Dosage & Frequency	Condition (or Symptom)	Specific instructions (e.g. on empty stomach/ with water, food, etc.)	Relevant side effects	Is refrigeration required?	Is Participant capable of self-administration?
Example: Albuterol inhaler	90 mcg/ 2 puffs every 4-6 hours as needed	Asthma	Shake before use	Rapid heartbeat, jitteriness, flushing	No	Yes

Part B: Non-Life Saving Medications

My minor participant has my permission to self-administer the following medication.

Medication Name	Dosage & Frequency	Condition (or Symptom)	Specific instructions (e.g. on empty stomach/ with water, food, etc.)	Relevant side effects	Is refrigeration required?	This authorization is effective for: (dates)

_____ _____ _____

Parent/Legal Guardian's Name (Please Print) Parent/Legal Guardian's Signature Date