

Parent/Legal Guardian Consent and Release Form for Minor Participants

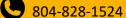
This release is for		's participation in						
Name of Minor Participant								
	, herea	after referred to as "the Program."						
Program Name								
Consent								
	nmunication and Notificati	ion Plan, and I fully understand						
and consent to the policies and		,						
Authorized Adults								
my minor participant to the Pr I understand that these individ valid photo ID to Program Staf	ogram in both regular and luals must be 18 years of a ff when asked. de a signed court order ba	age or older and must present a						
Name of Authorized Adult	Phone Number	Relation						
·	m's supervisory responsit	res in and out of the Program. I bility of my minor participant only heck-out.						
Media Release	et e al composito de la compos	to della colonia della Marchia						
For valuable consideration her	ein acknowledged as rece	eived, I hereby grant to Virginia						



to:













Commonwealth University (VCU), its affiliates, legal representatives, and assigns, and those acting with VCU's authority and permission, the irrevocable right and permission

- 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 making 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 <u>by Program Staff</u> 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, 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
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,
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,
employees, officers, directors and assigns are not responsible for any and all claims,
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

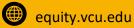












Date



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 Ge	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 medications, insect stings, or plants?	_	_	t not limited to,	
DIETARY RESTRICTIONS				
Does Participant have any dietary res	strictions?			











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:



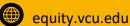












Please list any additional medical	coverage:
Please fill out the below informati	ion for the insurance policy holder.
Name & Relationship:	Date of Birth:
Address:	
Phone:	Email:
☐ Check here if your personal he (not from Virginia).	ealth insurance policy is an out-of-state Medicaid policy
Part 2: AUTHORIZATION FOR ME	DICAL CARE
provide medical care or medical in of my minor participant. • I give permission to the Program participant if they become hurt/injut treatment does not include provide. • I agree to the release of this medical events of the release of this medical events. • Virginia Commonwealth University information about your minor participate the stored, archived, and disposed. • If there is insufficient time to conform, I give permission to the Program.	agree that Virginia Commonwealth University does not insurance to cover emergency care or medical treatment. Staff to give basic first aid treatment to my minor jured during the Program activities. Basic first aid ding medications other than life-saving medication. dical form to the appropriate medical care provider. Sity is committed to protecting the sensitive personal rticipant's medical or other conditions. Information will to faccording to the University record retention policies. Intact me, or the emergency contacts designated on this gram Supervisor to consent to the following for my ensed health care practitioner acting within the scope of
☐ Non-emergency medical care to blood, and urine tests) and me	that includes routine diagnostic procedures (e.g., x-rays, edical 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
 quardian at the end of the day or, if overnight, program.

\square No, my minor participant does not need to take any medication while at the Progran	า
☐ 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

Parent/Legal Guardian's Name (Please Print)

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)









Date





912 W. Grace St., 2nd floor

Parent/Legal Guardian's Signature