Northern Wyoming Community College District (Sheridan College)
Youth Program/Camp Medical Information and Release Form

PROGRAM/CAMP INFORMATION

Program/Camp Name: _____

As a student, parent or guardian I understand that the information requested on this form is intended to help inform program staff of any pre-existing medical conditions. If participant 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 only be shared with your permission.*** Sheridan College requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment for Participant. You are accountable for providing an accurate medial history. **Final determination about whether to participate is the responsibility of you and your physician.** If Participant has any medical issue that is not requested below, but which you think is important, please included that information. It is recommended that you consult with a physician prior to participating is this program. If you are uncertain about any pre-exciting medical conditions, it is your responsibility to consult with your own physician prior to participating in this Program.

I understand that Sheridan College does not offer any form of insurance for Participant while participating in Program.

PART 1. GENERAL INFORMATION

Participants Name: _____ (hereafter "Participant")

Parent/Legal Guardian Name (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Home/Cell Phone _____ Work Phone _____

Date of Birth _____ Gender _____

Please list two emergency contacts:

Emergency Contact #1 Name	Cell Phone #	Work Phone #	Relationship
Emergency Contact #2 Name	Cell Phone #	Work Phone #	Relationship

PART 2. MEDICAL INFORMATION

Primary Care Physician: _____ Phone #: _____

Medication(s) Prescriber

_____ **No, this Participant does not need to take any prescription medication while at this Program.**

_____ **Yes, this Participant does need to take prescription medication while at this Program.**

- Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address, and phone number for pharmacist or prescriber.
- Container must hold only the amount required for the time the camper will be attending this Program.
- All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to this Program under the condition that the camper can self-manage care and delivery of medication and understand that under NO circumstance can medications be shared with other Participants.
- By checking "YES" above, I hereby affirm that this Participant has been instructed in the proper self-administration of the prescribed medication (s).

(Note: this is a two page legal document, please complete the back-side of this document)

Medication (s) you take, and for what Conditions(s): _____

_____

Allergies (food, environmental & to medications) & Nature of Reactions:_____

_____

Have you been under the care of a Physician in the past 12 months?_____

If so, for what reason? _____

Do you have, or have you ever been diagnosed with any of the following? Please check

Asthma □ Diabetes □ Seizures □ Heart Condition □ High Blood Pressure □ Broken Bone or Joint Injury □

Please elaborate:_____

PART 3. AUTHORIZATION FOR MEDIACL CARE

Parent/Guardian Authorization, Waiver and Consent for Over-the-Counter Medication

Over-the Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant's parent/guardian. Note: Unless we have parental/guardian authorization, we cannot administer ANY medications.

_____**No, this participant cannot be administered ANY OTC medication while at this Program.**

_____**Yes, this participant may be (if needed) administered ANY OTC medication while at this Program.**

With the above checked "YES" I authorize the administration of the over-the-counter medications to the participant as indicated on this form. I shall indemnify and hold harmless the Camp staff, Sheridan College, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my participant being administrated over-the-counter medications while at this Program. Participant has my permission to receive medical attention in the event of illness or medical emergency while participating in this Program. I will assume the financial responsibility for any cost of health care for my participant that may occur during this Program, including emergency evacuation.

As a participant, parent, or guardian I understand and acknowledge that my failure to disclose relevant information may result in harm to Participant and/or other during this Program. By signing my name I represent and warrant that I have provided all the important information to Sheridan College pertaining to my Participant's medical, mental, and physical condition and that it is accurate and complete. I agree to notify Sheridan College of any changes in their mental, physical or medical condition prior to Participant's scheduled Program.

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

I hereby authorize the release of this information to the appropriate medical personnel and appropriately trained NWCCD staff or camp staff.

Participant's Signature:_____ Date:_____

ENDORSEMENT FOR MINORS

As parent and/or guardian of the above named minor (i.e. under age of 18 years), I have read the above release, and hereby agree to all the provisions thereof. In witness whereof, I have here under set my signature on this day of_____, 20_____.

_____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian

Sheridan College
1 Whitney Way
Sheridan, WY 82801
307.675.0505