

Greetings, Parents!

Your child will soon visit Boston University Sargent Center for an environmental and adventure education program. The health and safety of your child is important to us. Please review the following information before completing. The HEALTH INFORMATION AND CONSENT FORM. (pages 1 and 2) **must** be completed by the parent/guardian. The child's physician must complete the HEALTH MEMORANDUM (page 3). If you have questions, call (603) 525-3311.

EXPLANATION

- 1) **Medical Consent: (page 1)** Addresses two areas: **First**, "I consent to and authorize...", a parent or guardian **must** sign for a Sargent Center staff to provide medical care. The second area requires a parent or guardian's signature **only** if you want certain medical care withheld.
- 2) **Waiver and Release: (page 1)** Parent or guardian must sign this section. **Children without signed waiver forms may not participate in School Programs.**
- 3) **Health Information (page 2)** Parent or guardian must fully complete this portion. Please note: Your child must be kept home for at least 24 hours if showing signs of a contagious illness when he or she is scheduled to visit BUSC. If your child has been ill for 2 days before attending BUSC or has had a serious injury, please keep your child at home. A doctor's release is required for an ill or injured child to attend.
- 4) **Health Memorandum for Sargent Center: (page 3)** Any child visiting Sargent Center must have had a complete physical examination within two years of attendance. The form on page 3 may be used for this purpose and must be accompanied by the child's immunization records. Alternatively, a signed physical undertaken for any other purpose (such as summer camp or athletic activities) or the current school physical form may be submitted instead accompanied by the child's immunization record.

MEDICATION INFORMATION

New Hampshire state law prohibits children keeping medications. Therefore, all prescription medications, over-the-counter medications, inhalers, Epi-pens, vitamins, Homeopathic medications and medicated creams will be collected at school, checked in, and stored in Sargent Center's Health Center. Inhalers and Epi-pens are exceptions. They are held by staff and are available to children at all times while at Sargent Center. Please note, they must be in the original container or they will not be administered.

- ❖ **Sargent Center Medications:** Sargent Center staff work in conjunction with our physician, keeping on hand generic equivalents of many common over-the-counter medications such as Tylenol or Advil. To allow your child to receive these medications, you must give your permission by completing section 3A, page 2.
- ❖ **Sending Non-Prescription Medications to Sargent Center:** Non-prescription medication must be in the original container with the administration directions intact (no baggies or film containers, please). Label each package with your child's name and the school's name, and place in a clear plastic bag. Section 3B (page 2) must be completed and signed by parent/guardian to permit Sargent Center staff to administer these medications.
- ❖ **Sending Prescription Medications to Sargent Center:** Each prescription medication must be in its original pharmacy container with the child's name, dosage instructions, and physician's name. Complete directions with a physician's signature must accompany the medication (see section 4A page 3). Dosage and administration instructions on the container must be the same as directions with physician's signature and parent's instructions.

There are **five** places that require a parent/guardian signature and **one** place for a physician's signature. Please be sure you have signed in each place and have provided all pertinent information. Make sure you have followed all instructions for sending supplies and medications to Sargent Center.

SUPPLEMENTAL INSURANCE: Any person participating in Sargent Center programs sponsored by Boston University are covered by the University's Sargent Center Accident Policy. This **supplemental** policy covers accidental injury occurring in the course of attendance at the center. The policy provides excess coverage in the form of blanket accident medical reimbursement of \$10,000 maximum with a deductible of \$50 or any other valid and collectible insurance coverage, whichever is greater. The policy also provides accidental death and dismemberment coverage in the principal sum of \$20,000 with no deductible.

BOSTON UNIVERSITY SARGENT CENTER

HEALTH INFORMATION AND CONSENT FORM FOR SCHOOL PROGRAM

(Page 1 and 2 to be completed by Parent/Guardian, Page 3 to be completed by physician. We suggest retaining a copy of this form for your files, as it cannot be released or used for any other program.)

Name _____ Date of Birth _____ Gender ____ Age _____ Ht. _____ Wt. _____

Custodial Parent's/Guardian's Name(s) _____

Mailing Address _____ City _____ State ____ Zip _____

Preferred e-mail address _____

1st Parent Home Phone (____) _____ Bus. Phone (____) _____ Cell Phone (____) _____

2nd Parent Home Phone (____) _____ Bus. Phone (____) _____ Cell Phone (____) _____

Please list any additional parent/guardian phone numbers on a separate piece of paper and attach to this form.

Emergency Contact (other than parent) _____ Home Phone (____) _____

Business Phone (____) _____ Cell Phone (____) _____ Relationship to Child _____

Child's Doctor _____ Phone (____) _____

Child's Dentist _____ Phone (____) _____

Child's Orthodontist _____ Phone (____) _____

Health Insurance Co. _____ Policy # _____

1. MEDICAL CONSENT: Must be signed by parent/guardian

I consent to and authorize emergency and non-emergency medical care to be provided to my child in the event of a health problem, emergency or injury occurring during my child's attendance at camp. I give my consent and authorization to the camp director or his/her designee to use his/her judgment in seeking medical care for my child. I understand that an attempt will be made to contact me in the event that medical care is needed, and that I am responsible for all medical costs incurred in treating my child* (See page 2 for information on BUSC's supplemental insurance).

Signature of parent/guardian _____ Date _____

Optional: If you wish for religious or other reasons, you may indicate your refusal to consent to certain medical care (i.e., blood transfusions), as follows: Notwithstanding the above, I do not consent to the following diagnostic tests or medical treatment for my child: Specify

Signature of parent/guardian _____ Date _____

2. WAIVER AND RELEASE: Must be signed by parent/guardian

I wish to enroll my child in the Program/Activity referred to above at Sargent Center, Hancock, New Hampshire. I recognize that some of the activities at Sargent Center involve physical risk, including the risk of serious injury. I hereby agree, on behalf of my child and myself, to assume all of the risks in connection with my child's attendance at Sargent Center and to release Boston University from any and all liabilities and claims whatsoever arising out of my child's participation in Sargent Center activities including travel, except insofar as such liabilities and claims arise out of Sargent Center's gross negligence or willful misconduct. I understand that in the event of an illness or behavioral problem, I may be required to pick up my child. The term Boston University shall include the corporation named Trustees of Boston University and its successors, trustees, officers, agents, representatives, contractors and all persons for whose conduct the University is or could be legally responsible. I agree that the laws of the Commonwealth of Massachusetts shall govern this waiver and release. I affirm that I have read and understood this document.

Signature of parent/guardian _____ Date _____

PROMOTIONAL RELEASE: Must be signed by parent/guardian

I authorize BUSC to reasonable use of any and all images and statements of/by/about the camper during any part of the BUSC experience for promotional purposes.

Signature of parent/guardian _____ Date _____

3. IMPORTANT HEALTH INFORMATION: (To be completed by parent or guardian). To make your child's stay at Sargent Center as safe and pleasant as possible, please complete in full.

1. Allergies: Food, drug, or other allergies (insect bites, pollen)? ____ If yes, what? _____
Type of reaction: _____

2. Any existing medical or behavioral conditions (physical, mental or emotional)? _____

3. Is there any factor that makes it advisable for your child to limit program of physical activity, i.e. heart condition, recent fracture, surgery, asthma or fears? _____ If yes, describe? _____

4. Is your family experiencing any stressful situation (such as divorce, serious illness, or death) that might be a concern to your child at this time? _____

5. Dietary needs? (including vegetarian and lactose intolerant) _____

If yes, call the nurse at least one week prior to attendance to discuss special needs (603-525-3311, ext 19).

6. In order to protect your child from possible embarrassment, what would you like Sargent Center staff to know? _____

7. Does your child wet the bed? _____ Walk in his/her sleep? _____

8. Is your child prone to homesickness? ____ If yes, what are the indicators? _____

4. PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS THROUGH HEALTH CENTER.

Listed below are medications available at Sargent Center for occasional use as needed. Please check those medications your child may receive and sign on parent/guardian line.

For headache/minor pain:

___ Tylenol (acetaminophen)

___ Advil (ibuprofen)

For stomach/bowel upset

___ Tums

___ Maalox

___ Pepto Bismol

___ Milk of Magnesia

For cold/allergy symptoms:

___ Sudafed

___ Benedryl (diphenhydramine)

___ Claritin (loratadine)

___ Robitussin cough syrup

___ Throat Lozenges

For Poison Ivy:

___ Zanafel

___ Buji Wash

___ Calamine or Calagel Lotion

Other topical products:

___ Insect Repellent

___ Sunscreen

___ Hydrocortisone Ointment

___ Benadryl Anti-itch Gel

___ Aloe Vera

Does your child swallow pills? ____

I authorize the camp nurse or designee to assess the need for and appropriately administer the above checked medications.

Parent/Guardian Signature _____ **Date** _____

5. IF YOUR CHILD IS BRINGING NON-PRESCRIPTION (over the counter) MEDICATION TO CAMP, PLEASE COMPLETE AND SIGN THIS SECTION. MEDICATIONS MUST BE IN ORIGINAL CONTAINERS. BUSC IS FORBIDDEN BY STATE LICENSING LAW TO DISPENSE MEDICATIONS THAT ARE NOT IN THEIR ORIGINAL CONTAINERS.

Medication Name: _____ Reason for administration _____

Complete directions for administration _____

Medication Name: _____ Reason for administration _____

Complete directions for administration _____

The above information and directions for administration of all medications is complete and correct. I authorize the camp nurse or his/her designee to use his/her discretion in giving the above medications as indicated.

Parent/Guardian Signature _____ **Date** _____

* **SUPPLEMENTAL INSURANCE:** All persons who participate in the Sargent Center programs sponsored by Boston University are covered by the University's Sargent Center Accident Policy. This *supplemental* policy covers accidental injury occurring in the course of attendance at camp. The policy provides excess coverage in the form of a blanket accident medical reimbursement of \$10,000 maximum with a deductible of \$50 or any other valid and collectible insurance coverage, whichever is greater. The policy also provides accidental death and dismemberment coverage in the principal sum of \$20,000 with no deductible.

**BOSTON UNIVERSITY SARGENT CENTER
HEALTH MEMORANDUM**

(This form or its equivalent must be completed by a physician or nurse practitioner)

New Hampshire State law recommends any child attending camp will have had a physical examination within **two** years of attending camp. **Physician's orders for prescription drugs to be taken at camp must be written within the current year.**

Name of Child _____ was examined on the following date _____.

In addition, the health history and immunization records have been reviewed.

Any existing medical condition (chronic or recurring illnesses?) _____

Health History (Please check all that apply)

_____ Allergies:
 Drug (specify) _____ Type of reaction _____
 Food (specify) _____ Type of reaction _____
 Environmental (specify) _____ Type of reaction _____
_____ Asthma (Type) _____ Well controlled? _____
_____ ADD or ADHD _____ Well controlled? _____
_____ Mood or mental health disorder _____ Well controlled? _____
_____ Diabetes (age of onset) _____ Well controlled? _____
_____ Heart Condition (specify) _____ Any limitations? _____
_____ Seizure Disorder (type) _____ Well controlled? _____

Are there any factors which would preclude this child from participating fully, including a high ropes course, in the Sargent Center program? () Yes () No Specify activities to be limited: _____

EXCEPTION, COMMENTS, CONCERNS SPECIAL PROBLEMS, ETC.

Date of most recent exam _____ Last Tetanus Toxoid Immunization _____

Immunizations: _____ copy attached or _____ verified up-to-date.

Physician's Signature _____ **MD Phone** (_____) _____

Print/Stamp Name

PHYSICIAN ORDERS FOR PRESCRIPTION MEDICATION

(Must be completed and signed by physician in order for BUSC to give medications)

MEDICATIONS MUST BE IN ORIGINAL CONTAINER. THE DIRECTIONS ON THE CONTAINER MUST MATCH THE PHYSICIAN'S WRITTEN ORDERS. A WRITTEN ORDER SIGNED BY THE PHYSICIAN MUST BE RECEIVED TO AUTHORIZE ANY CHANGE IN DIRECTIONS.

Is this child on any prescription medications? () Yes () No

1. Medication and dosage _____ Times of administration _____
Reason to administer _____
2. Medication and dosage _____ Times of administration _____
Reason to administer _____
3. Medication and dosage _____ Times of administration _____
Reason to administer _____

Physician's Signature _____ **MD Phone** (_____) _____