Seton Hall University Camp Program Medical Treatment Authorization

This form must be completed and returned before camp/program/event enrollment dates in order for camper to be permitted to participate in any Seton Hall sponsored programs or activities involving minors.

Personal Information

Camper's Last Name _____ First Name _____ Birthdate _____ ☐ M ☐ F

Specify camp your child will be attending _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ E-mail Address _____

Parent/Guardian #1 _____ Parent/Guardian #2 _____

Daytime Phone _____ Daytime Phone _____

Place of employment _____ Place of employment _____

Health Insurance Carrier _____ Health Insurance Carrier _____

Policy Number _____ Policy Number _____

Name of Family Physician _____ Phone _____

In case of emergency, please notify:

If neither parent nor guardian is available in an emergency, please contact:

1. _____ Phone _____
2. _____ Phone _____

Health History [Please check and provide approximate dates that camper suffered from allergies or other conditions listed below]

Allergies

☐ Hay Fever ☐ Bee/Wasp Stings ☐ Insect Stings ☐ Penicillin ☐ Peanut ☐ Other Food/Drugs: _____

Other

☐ Asthma ☐ Diabetes ☐ Convulsions ☐ Concussion ☐ Behavioral/Emotional ☐ Other: _____

Date of most recent tetanus immunization: _____

Please list any ***major*** past illnesses (contagious and non-contagious): _____

Please list any ***major*** operations or serious injuries (include dates): _____

Has the camper ever been hospitalized? If so, when? _____

Please list any chronic or recurring illness: _____

Is there anything else in camper's health history that the camp staff should know? _____

Are there any activities from which the camper should be restricted? _____

Does the camper have any special dietary restrictions? ☐ No ☐ Yes If YES, explain: _____

Does the camper wear any medical appliances (glasses, contact lenses, etc.)? ☐ No ☐ Yes If YES, explain: _____

Will the camper need to take any medication at camp? ☐ No ☐ Yes Does the camper use an EpiPen ☐ No ☐ Yes

If YES to medication or EpiPen, please complete the Camper Camp/Program/Event Medication Form

In the event of an illness or injury, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and if I cannot be reached, I understand that the Program Designee or designee will call 911. I understand the University Health Services department does not provide services to campers attending camps, programs or activities and that it is my responsibility to pay any medical bill that may be incurred should my camper need medical care while attending a Seton Hall University sponsored program or activity.

I understand that Seton Hall University does not provide medical insurance to cover emergency care or medical treatment of my camper.

_____ _____

Parent's/ legal guardian's name (please print) Signature

_____ * Terms and Conditions agreed to via electronic signature

Date: _____

Camper Camp/Program/Event Medication Form

Name of Participant (print): _____

Name of Program (print): _____

Date of Birth (mm/dd/yyyy): _____

Please list the specific prescription or over-the-counter medications below, reasons for medication, daily dose. If any medications change prior to arriving at the camp/program/activity ("Program"), please provide an updated list upon arrival.

	Medication	Reason(s) for Medication	Daily Dosage/Time(s) Taken/Route of Administration
1			
2			
3			
4			

If at all possible, medication should be administered at home. Medications will be allowed at the Program only when failure to take such medicine would jeopardize the health of a participant and he/she would not be able to attend the Program if the medicine were not made available.

The parent/legal guardian of a participant is required to disclose their intention to bring medications to the Program, especially to treat potentially life-threatening conditions (i.e. inhalers, EpiPens, insulin injections), at least three (3) days before the start of the Program. Upon arrival to the Program, parent/legal guardian should plan to meet with the Program Director or designee at registration to review medication issues for a Program participant. For identification purposes, a current picture of the participant is to be provided upon registration.

The parent/legal guardian is responsible for ensuring that all medications (prescription and over-the-counter) are stored in the original product packaging and clearly labeled with the participant's name. Prescription medication(s) must also include a label with the medication's name and dosage instructions, as well as the prescribing physician's name and telephone number.

All medications will be kept in a container used exclusively for storage of medications. Medications that require refrigeration will be stored in a refrigerator. Access to all medications will be limited to approved personnel. The need for emergency medication may require that a Program participant carry the medication on his/her person or that it be easily accessed (i.e. inhalers, EpiPens, insulin injections). It is the responsibility of the parent/guardian to alert the Program director to this need. Authorized Adults will NOT purchase medications of any type (prescription and over-the-counter) for Program participants of any age.

Authorized Adults will not dispense medications, but may monitor the self-administration of certain medications, if necessary, ONLY upon written consent of the parent/legal guardian and/or physician's orders. Some Authorized Adults may be trained in the use of an EpiPen and, with written consent of the parent/legal guardian, will inject. Otherwise, first responders will be called.

It is NOT permissible for a participant to share any medications with any other participants.

It is the responsibility of the parent/legal guardian to be sure that the participant's medications brought to the Program are picked up at the end of the Program. Failure to do so will result in the medications being destroyed within three (3) working days after the participant's last day at the Program. Absolutely no medications will be returned via mail regardless of circumstance.

Print name of the Parent or Guardian:

_____

Signature of Parent or Guardian:

_____ Date: _____

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If applicable, I consent to an Authorized Adult monitoring the self-administration of medications, if necessary.

Signature of Parent or Guardian:

_____ Date: _____

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If applicable, I consent to an Authorized Adult administering an EpiPen.

Signature of Parent or Guardian:

_____ Date: _____