MINOR YOUTH EMERGENCY MEDICAL CONTACT, HEALTH HISTORY AND TREATMENT AUTHORIZATION

Send this form to the address below by (date):

_____

Participant Name: _____

Participant Home Address: _____
Street Address City State Zip Code

Dates participant will attend program from_____to_____
Month/Day/Year Month/Day/Year

Gender_____ Birth Date__/__/____ Age on arrival: _____ Grade Completed:_____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed. Complete this form and send the original, signed form by the requested date to:.

PARTICIPANT EMERGENCY CONTACT AND TREATMENT AUTHORIZATION

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name:_____Relationship to Participant_____ Email: _____

Preferred Phones: (____) _____ (____)_____ (____)_____

Home Address: _____

(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name:_____Relationship to Participant:_____Email: _____

Preferred Phones: (____)_____ (____)_____ (____)_____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name:_____Relationship to Participant_____ Email: _____

Preferred Phones: (____)_____ (____)_____ (____)_____

Medical Insurance Information: *(Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable)*

This participant is covered by family medical/hospital insurance □ Yes □ No

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (____)_____

Parent/Guardian Authorization for Health Care

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all activities except as noted by me and/or an examining physician.

I have read and understand Montclair State University's Minor Youth Protection Policy regarding emergency medical treatment and medication administration for minor youth unaccompanied by a parent or legal guardian

I understand that Montclair State University Health Center does not provide medical care to minors who are not enrolled as Montclair State University students.

I give permission to the program's medication administrator and/or medical service provider selected by the activity sponsor to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations.

If I cannot be reached in an emergency, I give my permission to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child.

I understand information on this form will be shared on a "need to know" basis with activity sponsor and /or University staff.

I give permission to photocopy this form. In addition, the activity sponsor or medical service provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian Date: Relationship to Participant

PARTICIPANT HEALTH HISTORY

General Health History: *Check "Yes" or "No" for each statement. Explain "Yes" answers below.*

Has/does the participant:

1. Ever been hospitalized? ☒ Yes ☒ No
2. Ever had surgery? ☒ Yes ☒ No
3. Have recurrent/chronic illnesses? ☒ Yes ☒ No
4. Had a recent infectious disease? ☒ Yes ☒ No
5. Had a recent injury? ☒ Yes ☒ No
6. Had asthma/wheezing/shortness of breath? ☒ Yes ☒ No
7. Have diabetes? ☒ Yes ☒ No
8. Had seizures? . ☒ Yes ☒ No
9. Had headaches? ☒ Yes ☒ No
10. Wear glasses, contacts, or protective eyewear? ☒ Yes ☒ No
11. Had fainting or dizziness? ☒ Yes ☒ No
12. Passed out/had chest pain during exercise? ☒ Yes ☒ No
13. Had mononucleosis ("mono") during the past 12 months? ☒ Yes ☒ No
14. If female, have problems with periods/menstruation? ☒ Yes ☒ No
15. Have problems with falling asleep/sleepwalking? ☒ Yes ☒ No
16. Ever had back/joint problems? ☒ Yes ☒ No
17. Have a history of bedwetting? ☒ Yes ☒ No
18. Have problems with diarrhea/constipation? ☒ Yes ☒No
19. Have any skin problems? ☒ Yes ☒ No
20. Traveled outside the country in the past 9 months? ☒ Yes ☒ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel:

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement.*

Has the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☒ Yes ☒ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☒ Yes ☒ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☒ Yes ☒ No
4. Had a significant life event that continues to affect the participant's life? ☒ Yes ☒ No (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The program may contact you for additional information.

Diet, Nutrition:

The participant eats: ☒ regular diet. ☒ regular vegetarian diet. ☒ lactose intolerant. ☒ gluten intolerant. ☒ Other

Please explain:

Allergies:

☒ No known allergies.
☒ This participant is allergic to: ☒ Food ☒ Medicine ☒ The environment (insect stings, hay fever, etc.) ☒Other

Please describe below what the participant is allergic to and the reaction seen:

Health-Care Providers:

Name of participant's primary doctor(s):_____ Phone: (_)____

Name of dentist(s):_____Phone: (_____)_____

Name of orthodontist(s):_____Phone: (_____) _____

PARTICIPANT IMMUNIZATION RECORD

Grade Level (circle one)	DTaP (Diphtheria, Tetanus, acellular Pertussis)	IPV (Inactivated Polio Vaccine)	MMR (Measles, Mumps, Rubella)	Varicella (Chickenpox)	Hepatitis B	Meningococcal
K-Grade 1	4 doses with one of these doses on or after the 4th birthday OR any 5 doses	3 doses with one of these doses given on or after the 4th birthday OR any 4 doses	2 doses	1 dose	3 doses	None
2nd to 5th Grade	3 doses	3 doses	2 doses	1 dose	3 doses	None
6th Grade and Higher	3 doses	3 doses	2 doses	1 dose	3 doses	1 dose required for children born on or after 1/1/97 given no earlier than age 10

Immunization History: *Please circle your child's most recently completed grade and compare the required immunizations with your child's current immunization record.*

_ I have reviewed my child's immunization record and hereby certify that to the best of my knowledge, the immunization requirements are up to date.

_ I have attached a copy of the immunization record(s) for verification.

(or)

__ My child has incomplete immunizations or exemption. I have provided an explanation (attached)

_ I understand that if my child has incomplete immunizations or is exempted from vaccination, he/she may be excluded from participation during a vaccine preventable disease outbreak, or threatened outbreak, as determined by the Commissioner of the Department of Health.

I understand that reasonable measures will be taken to isolate any participant or staff member suspected of having a communicable disease, until medical assistance is obtained.

Signature - Parent/Legal Guardian: _____ Date: _____/_____/_____

Printed Name -Parent/Guardian: _____

PARTICIPANT MEDICATION ADMINISTRATION

Medication:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Medications required by a minor may be self-administered, when age appropriate, or may be administered by the parent/legal guardian or by a trained, medication administrator identified by the program sponsor.

Montclair State University requires original pharmacy containers with labels, which show the participant's name and how the medication should be given.

Provide enough of each medication to last the entire time the participant will be attending the program.

☒ This participant will not take any daily medications while attending the program

☐ This participant will take the following daily medication(s) while attending the program

MONTCLAIR STATE UNIVERSITY

WAIVER

Participant's Name (Please print): _____ (the "Participant")

Participant's Age: _____

In consideration for permitting Participant to attend _____ ("Event"), the Participant, for themselves, and for their respective heirs, personal representatives and assigns, agree as follows:

Assumption of Risk: The Participant acknowledges and agrees that he/she understands the nature of the Event; that Participant is qualified, in good health, and in proper physical condition to participate; that there are certain inherent risks and dangers associated with the Event; and that, except as expressly set forth herein, knowingly and voluntarily, accept, and assume responsibility for, each of these risks and dangers, and all other risks and dangers that could arise out of, or occur during, Participant's participation in the Event.

Release and Waiver: To the maximum extent permitted by applicable law, the Participant RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE Montclair State University, the New Jersey Educational Facilities Authority and the State of New Jersey or any subdivision thereof, and each of them, their officers, agents, and employees, (collectively, the "Releasees"), from and for any liability resulting from any personal injury, accident or illness (including death), and/or property loss, however caused, arising from, or in any way related to, Participant's participation in the Event.

Permission to Use Likeness: The Participant further agrees to allow, without compensation, Participant's likeness to appear, and to otherwise be used, in material, regardless of media form, promoting Montclair State University.

Choice of Law and Venue: As consideration for the University permitting me to participate in the Event, I agree and consent that any and all disputes arising from my participation in this Event and any and all claims for money damages that I, my heirs, representatives, and assigns may have or bring against the University which may arise from this Event shall be subject to the laws of the State of New Jersey and no action for monetary damages or other relief shall be brought in any jurisdiction other than the State of New Jersey. I agree that this Waiver is severable and that if any clause is found invalid, the balance will remain in effect, valid, and enforceable.

_____

Signature of Participant Date

_____

Signature of Parent/Guardian of Minor Date