

Activity Consent Form and Approval by Parent or Legal Guardian

First name of participant Middle initial

Last name

Birth date (month/day/year) **/ /** Age during activity

Address (need street address if you have a P.O. Box)

City State Zip Home Phone Parent Cell Phone

My child has approval to participate in (brief description of activities/program):

From (dates: month/day/year) **/ /** to **/ / .**

Without restrictions

Special considerations or restrictions :

# Hold Harmless Agreement

I understand that participation by my child involves a certain degree of risk. Examples **of potential specific, significant, non-obvious dangers and risks associated with this activity, include, but are not limited to:**

I have carefully considered the risk involved and give consent for my child to participate in the activity. I understand that participation in the activity is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release Oregon Health & Science University, the activity coordinators, and all directors, officers, employees, volunteers, agents, and related parties from any and all claims or liability arising out of this participation.

Parent/guardian signature Date

Parent/guardian printed name

# Authorization for Treatment of a Minor

Please list any of your child’s medical conditions that camp organizers should be made aware of including allergies:

Please list all prescription and non-prescription medications that you child is currently taking including medications that will need to be administered during the camp. Please note that special arrangements will need to be made if this is the case.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dose** | **Frequency** | **Administer During Program/Activity?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Doctor’s name: Doctor’s phone number:

Medical Insurance provider:

Policy #:

Phone number for Medical Insurance provider:

Name of policy holder:

In case of emergency involving my child, I understand every effort will be made to contact me. I further understand that I am financially responsible for any medical treatments or procedures that are necessary as a result of any injury sustained at Oregon Health & Science University.

In the event I cannot be reached, I hereby authorize the following individual to consent to proper treatment of my child, when I am unavailable:

-or-

The adult leader in charge of the activity (described on Page 1 of this document) at Oregon Health & Science University.

Full Name: Phone Number:

Relationship to me: Relationship to my child:

Proper treatment includes hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the person selected above: examination findings, test results, and treatment provided for purposes follow-up and communication with the participant’s parents or guardian and/or determination of the participant’s ability to continue in the program activities.

I understand that my authorization is given in advance of any specific diagnosis and such diagnosis may later require my specific consent before treatment can be provided. This authorization is valid for the time period noted on Page 1 of this document.

Parent/guardian signature Date

Parent/guardian printed name