KICKS KARATE AT MERCERSBURG ACADEMY SUMMER TRAINING CAMP

# MEDICAL FORM

**Instructions**: Parents should complete Parts 1, 3 & 4. ***Part 2 should be completed and signed by a physician.*** **All sections must be completed & signed; enter "None" if not applicable**. Accurate information will better enable us to provide quality care to your child/ward in case of a problem or emergency.

**Return this form to Kicks Karate by June 1st. Failure to submit this form by June 1st will result in forfeiture of registration fee.**

*Please type or print in blue or black ink.*

## PART 1 - GENERAL INFORMATION: *(All information must be provided)*

Program: Kicks Karate Summer Training Camp Dates of Program: 06/17 – 06/22 /2018

Participant's Name:_____ Date of Birth:____/____/_____

Parent Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency Contact other than parent:_____

Relationship to participant:_____ Phone:_____

Medical History: (Please list all health problems, including emotional and any physical limitations. Use a separate sheet if necessary.)

_____

_____

Current Medications:_____

Allergies (food, environment, medications, etc):_____

_____

Date of last Tetanus. Must be within 10 years: _____/_____/_____

## CONSENT FOR PARTICIPATION, MEDICAL AND SURGICAL TREATMENT

Permission is granted for full participation in the Summer Program, in accordance with the recommendation of the physician completing this form.

I consent to examination and treatment of my child by an area physician and consultants he/she may designate. In the event of an urgent problem and in the absence of the Medical Director, the Nurse Practitioner, the Program Director or a person the Program Director designates may give permission for necessary treatment.

I also consent to release of any information regarding treatment while at the program to my Family Doctor.

* **Parent/legal guardian signature**_____ Date:_____

## PART 2 - TO BE COMPLETED BY A PHYSICIAN

Name of participant:_____ has been examined by me on this date and found to be free from infectious and contagious disease. All health concerns have been listed above. He/She is physically qualified for full participation in activities related to the Summer Program.

M.D. Name:(print)_____ M.D. Signature:_____

Date: ____/____/____ Phone: _____ Fax: _____

## PART 3 - INSURANCE INFORMATION

Insurance Company: _____ Policy Holder:_____

Address: _____ Group Policy #:_____

City/State/Zip: _____ Individual #:_____

***PLEASE PROVIDE A PHOTOCOPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.***

(Failure to provide a copy of insurance card will result in camper not being allowed at camp)

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# MEDICAL FORM

**All sections must be completed & signed; enter "None" if not applicable**

## PART 4 - PRESCRIPTION AND OVER-THE-COUNTER (OTC) MEDICATION

*Information/Authorization for Administration*

***Please read carefully.*** These sections must be completed and on file in the participant's health record prior to the administration of any medication.

### BRINGING MEDICATION(s)

All medication should be provided at the time of registration. Please deliver the container(s) of medication in one (1) labeled, sealable, clear Ziploc type bag with participant's name clearly marked on the outside. Medication(s) must be delivered to the school by the parent/guardian in the container in which it was dispensed/purchased by the prescribing physician, licensed pharmacist or business. The Health Center **cannot** accept medication in any alternative containers.

Participants **should not** bring general over-the-counter (OTC) medications (Tylenol, Chloroseptic, Ibuprofen, etc.) unless on a regular regime of dosage. The Health Center and the Health Services Assocaite have these types of medications available for participants and will dispense them unless parents note otherwise (see below). Participants **should bring** regularly scheduled OTC medications (Claritin, other).

### DISPENSING OF MEDICATION

Medication will be kept by a Kicks Karate designee and will be generally dispensed as instructed, per parental/legal guardian and/or physician's instructions and written orders. When exceptional situations occur, self-medication will be supervised by a program staff member who has received instructions from the participant's parent/legal guardian or physician. All medication will be dispensed as prescribed by the physician and labeled by the pharmacy. No medication will be administered without the appropriate completed forms.

### CHANGES IN PRESCRIPTIONS/MEDICATIONS

There must be notification to the Kicks Karate Corporate Office(301-947-8445) if any information provided by the physician changes after submission of this medical form.

### STATEMENT OF UNDERSTANDING/ACKNOWLEDGEMENT

With full knowledge of any emergencies, dangers and risks related to the administration of medication, I/We, the undersigned, hereby waive all claims, which might arise from medication to our minor child and the results thereof. I/We agree to indemnify and hold harmless Kicks Karate, Inc., its owners, employees & assigns, The Regents of Mercersburg College, Mercersburg Academy, its members, officers, employees, servants & agents from any and all liability relative to the administration of such medication.

I/We have discussed appropriate use of any **applicable medicines/medication** with our child.

I/We understand that I/We must submit a revised statement and sign it if any medical information or a medical condition changes.

_____

_____

_____

Please list any medications that should **not be administered** to your child.

_____

_____

_____

_____ _____

Date **Parent/legal guardian signature**

**This form is valid for one (1) year from date of signature.**

KICKS KARATE AT MERCERSBURG ACADEMY SUMMER TRAINING CAMP

# MEDICAL FORM

**All sections must be completed & signed; enter "None" if not applicable**

## PART 4 - *CONTINUED*.....PRESCRIPTION AND OVER-THE-COUNTER (OTC) MEDICATION

*Information/Authorization for Administration*

Please complete as applicable. The following information is required when participants need regular administration of prescription and/or non-prescription medication while participating in the Kicks Karate Summer Program.

Participant's Name: _____
Last First

Program: Kicks Karate Summer Training Camp

Date of Birth: _____/_____/_____

Please complete the form below. If your participant does not take medicine please indicate below and submit with your other forms.

Name of medication(s) and time(s) (see choices) to be administered:

| | Medications | Administration Time | Dosage | As Needed? |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |

Special instructions for the administration of drug, on empty stomach, cold storage, etc.: _____

_____

_____

***By signing this section, I agree that the above information is complete and accurate. I accept that any supplemental changes must be received in writing to Kicks Karate before any changes can take effect.***

_____ _____ _____
**Parent/ legal guardian signature** Phone Date

_____ _____ _____
Ordering physician's name Phone Fax Date

**This form is valid for 1 (one) year from date of signature.**

If you have any questions or concerns, please call the Kicks Karate Corporate Office at 301-947-8445.