

**University of Wisconsin-Eau Claire**  
**CONSENT FOR MEDICATION ADMINISTRATION**

**TO THE PARENT(S) OR LEGAL GUARDIAN:**

If your son, daughter, or ward will be under the age of 18 while at the University of Wisconsin-Eau Claire, it is camp policy to secure your consent for prescription medication distribution and for the use of medical devices.

**All prescription medications must be in a medicine bottle and labeled with the camper's name, doctor's name and phone number, medication name and dosage. You must also complete the form below:**

\_\_\_\_\_ No prescription medication has been brought to camp.

\_\_\_\_\_ I understand that prescription medications or medical devices will be administered by the Camp Health Supervisor. However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

*All prescription medications brought to camp by a camper or staff member shall be in containers that are clearly labeled to include the name of the camper or staff member, the name of the medication, the dosage, the frequency of administration and the route of administration. All medication prescribed by a physician shall, in addition, be labeled to include the name of the prescribing physician, the prescription number, date prescribed, possible adverse reactions, the specific conditions when contact should be made with the physician and other special instructions as needed.*

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Name of Medication(s)	Prescribing Doctor	Doctor's Phone #
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Amount to be taken	How is it taken?	Time(s) to be administered
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Day(s) to be taken	SPECIAL INSTRUCTIONS:
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Signature of Parent or Guardian	Date
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**CONSENT FOR MEDICAL TREATMENT**

**TO THE PARENT(S) OR LEGAL GUARDIAN:**

- If your son, daughter, or ward will be under the age of 18 years while at our camp, it is our policy to secure your consent for medical treatment.
- By Signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-Eau Claire, their officers, employees and agents, from any and all liability, loss damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the camp/event.

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Participant Name – Please Print	Signature of Parent or Guardian	Date
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**UWEC Photo Consent**

I understand that the University may take photographs of camp participants and activities. I agree that the University of Wisconsin-Eau Claire shall be the owner of and may use such photographs relating to the promotion of future camps and in any University Publication. I relinquish all rights that I may claim in relation to the use of said photographs.

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Participant Name – Please Print	Signature of Parent or Guardian	Date
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This form should be completed in full. Please **return at least two weeks prior to your camp session**. If you are unable to return it two weeks prior to your session, you **must** bring it with you to registration. **No student may attend a summer camp without this form on file**. Please return, with designated signatures to:

**UWEC SUMMER SPORT CAMPS**  
**McPhee Phy. Ed Center**  
**UW-Eau Claire**  
**Eau Claire, WI 54702-4004**

<b>NAME OF CAMP/EVENT</b>	<b>PLEASE CIRCLE EACH CAMP YOU'RE PARTICIPATING IN:</b>						
<b>Boys B-Ball</b> 1 2 3 4	<b>Swimming</b>						
<b>Girls B-Ball</b> 1 2 3	<b>Hockey</b>	Mites 1 2	Squirts	PeeWee	HS Div.	U14 Girls	HS Girls
<b>Volleyball</b> 1 2 3 4 5 6 7 8 9	<b>Softball</b>	Gr. 5-8	Gr. 9-12				<b>Golf</b>
<b>Soccer</b> Ultimate CoEd Camp Day Camp	<b>Football</b>	Youth	7 on 7				<b>Gymnastics</b>

<b>PARTICIPANT:</b>	<b>LAST</b>	<b>FIRST</b>	<b>MIDDLE</b>
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<b>HOME ADDRESS:</b> Street _____ City _____ State _____ Zip _____	<b>HOME TELEPHONE #</b> ( ) -	<b>Date of Birth</b> / /	<b>Sex:</b> <b>M</b> <b>F</b>
		<b>Height:</b>	<b>Weight:</b>

<b>PARENT/GUARDIAN:</b>	<b>RELATIONSHIP:</b>	Does participant have allergic reactions to: <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No Other Antibiotics: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medicines (type): _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Insect Bites/Stings: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____
<b>ADDRESS :</b> (If different than above)	<b>HOME TELEPHONE #</b> ( ) - <b>WORK TELEPHONE #</b> ( ) -	

Physician: _____ Telephone #: ( ) _____	Does participant take medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Identify _____
Name of Insurance Co: _____ Policy #: _____	

**I do not have medical insurance but I will be totally responsible for payment of medical care.**

**Parent/Guardian Signature:** \_\_\_\_\_

Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness. (Name, relationship, address, telephone number)	Has participant had or presently experiencing: <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures/Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Injury/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Emotional Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Neck/Back Pain/Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer Other:
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<b>Immunization Record:</b> <ul style="list-style-type: none"> <li>• MMR (Measles, Mumps, Rubella)              Dose 1 – Immunization at age 1 <input type="checkbox"/> Yes <input type="checkbox"/> No              Dose 2 <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Tetanus-Diphtheria <input type="checkbox"/> Yes <input type="checkbox"/> No              Year of last tetanus boost ____ / ____ / ____ ( Must be within last 10 years.)</li> </ul> Has participant ever had major surgery or been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain any significant operations, accidents or illnesses, and last medical attention and reason:  Does participant have any physical condition(s) requiring special considerations? Explain.	
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<b>Participant must have had a physical examination within 24 months of the camp/event participant is registering for in order to participate. Please furnish date of the last physical examination. ____ / ____ / ____.</b>	<b>MUST COMPLETE REVERSE SIDE TO PARTICIPATE!</b>
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