MEDICAL INFORMATION & CONSENT / STRINGWOOD WAIVER

EMERGENCY CONTACT INFORMATION

____ ____________________________

Name of Summer Program — Date of Program

____ ____________________________ _______________

Name of Participant — Birth Date — Age

____ ___________________________________

Mother /Guardian (if participant is a minor) — Home telephone/Work telephone

____ ___________________________________

Father /Guardian (if participant is a minor) — Home telephone/Work telephone

____ ____

Emergency Contact person — Relationship and telephone

Student resides with: _____ Both Parents _____ Mother _____ Father _____ other (please explain):

PHYSICIAN INFORMATION

____ _____________________________________

Family Physician — Telephone

____ _____________________________________

Family Dentist — Telephone

____ _____________________________________

Specialist — Telephone

IMMUNIZATION/VACCINE RECORD

The participant has been immunized in accordance with the recommended immunization schedules approved by the CDC and the American Academy of

Pediatrics _____ Yes _____ No _____ Date of last Tetanus booster:__________________________

Has the participant received the Covid-19 vaccination? _____ Yes _____ No

Date of first vaccine:___________________________

Date of second vaccine (if applicable):____________________________

Has the participant received the Covid-19 booster (if applicable)? _____ Yes _____ No

Date of booster:______________________________

Any serious or ongoing medical problems (i.e. diabetes, duodenal ulcers, asthma, etc.?) _____ Yes _____ No
If yes, please attach a note with more detail.

Is the student on medication? _____ Yes _____ No If so, for what condition?_________________________

Any current restrictions on activity? _____ Yes _____ No If yes, please explain_________________________

ALLERGIES

TYPE – Food, Medication, Insect — DESCRIBE REACTION

____ ____

____ ____

MEDICATIONS

If the participant is currently taking medication, please list below:

NAME OF MEDICATION	DOSAGE	FREQUENCY	DIAGNOSIS
______________________________	________________	________________	______________________
______________________________	________________	________________	______________________
______________________________	________________	________________	______________________

Does the participant need any special consideration on the advice of a physician? _____ Yes _____ No

Does the participant need any special consideration on the advice of a psychiatrist, psychologist, or mental health therapist? _____ Yes _____ No

If the answer is yes to either of the previous questions, a letter from the participant's physician or counselor/therapist should be attached or sent separately to Nancy Oliveros, Director, STRINGWOOD. Such information will be considered confidential and privileged. If there is anything in your religious beliefs that should be given consideration in the treatment of the student's health or in case of an emergency, please enclose a note of explanation.

MEDICATION POLICY

All medications must come to STRINGWOOD in separate original labeled containers. Medications must not expire before the end of the session. Prescription medications must be written in the name of the student. **Please note that STRINGWOOD and EAGLE BLUFF staff are unable to administer any medications and that we must have a completed ADMINISTRATION OF PRESCRIPTION MEDICATION FORM on file for them. Please see this form at the end of this document.**

MEDICAL INSURANCE INFORMATION

____ Name of Policyholder

____ Medical Insurer Name

____ Policyholder ID#

____ Plan Type

____ Policyholder Date of Birth

____ Insurer Address

____ Relationship to Participant

____ Insurer Telephone

____ Policyholder Phone

____ Group Name / Group ID

AUTHORIZATIONS AND CONSENT FOR MEDICAL CARE AND REFERRAL

I consent to authorize STRINGWOOD to refer _____ myself _____ my child (check one) for consultation to any license medical specialist as judged necessary and give authority and power to any such physician or surgeon to render all such diagnostic procedure, examinations, care or treatment that he/she may deem necessary or advisable. Parents will be charged for all medical fare. Dental work, prescriptions, antibiotics, glasses x-rays, consultations, and transportation required for such appointments. A STRINGWOOD faculty or staff member will accompany the student as circumstances warrant.

____ Participant Signature (must be 18 years or older), or Parent/Guardian Signature

_______________________ Date

SERIOUS ACCIDENT OR ILLNESS

In case of serious accident or illness involving myself or my child while he/she is in the custody of STRINGWOOD or its employees, every effort will be made to contact parent or guardian. A situation may arise when emergency treatment may be necessary, and the parent cannot be reached. In such situation, I authorize STRINGWOOD personnel to make a decision for treatment with the appropriate medical personnel or facility. It is also understood that the participant is financially responsible for any costs incurred as a result of treatment.

____ Participant Signature (must be 18 years or older), or Parent/Guardian Signature

_______________________ Date

PARTICIPANT WAIVER FORM

The participant:____
Please print
And if the participant is a minor, the applicant's parent, or legal guardian:____
Please print

- Agree to comply with all program requirements including meeting payment and form completion deadlines.
- Understand that no deduction or refunds will be made for late arrival, early departure, or expulsion.
- Give permission for the applicant to attend all functions and activities connected with Stringwood including any that include travel off-campus.

I understand that as part of my (child's) participation in the Program that there are dangers, hazards and inherent risks to which I (my child) may be exposed, including the risk of serious physical injury or illness (including but not limited to Covid-19), temporary or permanent disability, and death, as well as economic and property loss. I further realize that participating in Stringwood may involve risks and dangers, both known and unknown, and I have chosen to (allow my child to) take part in the Program. Therefore, I, and on behalf of my child, have determined that it is reasonable to accept all risk of injury, loss of life or damage to property arising out of training, preparing, participating, and traveling to or from the Program and I do voluntarily accept and assume those risks. I release Stringwood Executive Directors, faculty, staff, and volunteers from all actions, claims, or demands for damages resulting from my, or my child's participation in the activities, and from liability and damages, injuries, or losses that might be sustained by myself or my child, except those caused by the direct and sole negligence of the aforementioned organization.

I agree that the terms and conditions of this Agreement are binding on my representatives, heirs and assigns.

____ _________________
Participant Signature Date

____ _________________
Parent/Guardian Signature Date

MEDIA, PHOTO & VIDEO RELEASE FORM

_____ YES, I give permission for my child to be:
_____ NO, I do not give permission for my child to be:

photographed and/or videographed for STRINGWOOD. The resulting photography may be subsequently used without compensation to me by STRINGWOOD, or third parties for publications (including web sites), advertising, and/or publicity purposes at the discretion of STRINGWOOD. I waive the right to inspect or approve the finished photography and/or publication use.

PARENTS' AND PARTICIPANT'S ACKNOWLEDGEMENT

Answers to the questions above are valuable to health care while at STRINGWOOD. Questions must be answered fully and correctly. STRINGWOOD reserves the right to dismiss any student or to cancel any contact if incorrect information is supplied on this form. I certify that all the answers I have given on this medical information form are accurate to the best of my knowledge.

____ _________________
Participant Signature Date

____ _________________
Parent/Guardian Signature Date

SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION FORM

____
Name of Summer Program

____
Date of Program

____
Name of Participant

____
Birth Date

____
Age

This form must be completed fully in order for participants to self-administer required medication. State law requires that a written emergency care plan must be on file that is "prepared by a licensed physician in collaboration with the minor and the minor child's legal parent or guardian, and that is updated as necessary for changing circumstances." A new medication administration form must be completed for each medication and/or each time there is a change in dosage or time of administration of a medication. Self-medication requires licensed health care authorization and signature, and parent signature.

_____ My child does not need to take any prescription medication while at the program.

_____ My child will need to take prescription medicine while at the program.

_____ My child needs to keep this medication with them at all times for emergency care.

All prescription medications, including medications for conditions such as food, drug or insect allergies diabetes; asthma; or epilepsy may be brought to STRINGWOOD under the condition that the participant can self-manage care and delivery of medication with written authorization to do so by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. The label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only standard dose vials or the amount required for the time the participant will be attending the Program.

MEDICATIONS

Please list medications below:

NAME OF MEDICATION	DOSAGE	FREQUENCY
______________________________________	______________________	_____________________________
______________________________________	______________________	_____________________________
______________________________________	______________________	_____________________________

____ ________________
Participant Signature (18 and above) Date

____ ________________
Parent/Guardian Signature Date