UNIVERSITY OF CENTRAL FLORIDA

Youth Protection Program
Medical Information and Authorization for Medical Care

Program/Activity Name _____

Today's Date:_____/_____/_____

Basic Personal Information (please print)

Child's Name:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone Number:_____ Alternate Phone Number: _____

Date of Birth: _____Height: _____ Weight: _____

Emergency Contact Information

Person to contact in case of emergency:_____ Relationship:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone Number:_____ Alternate Phone Number:_____

Family Physician:_____ Phone Number:_____

Insurance Provider:_____ Phone Number:_____

Insurance subscriber name: _____

Group Number:_____ Policy Number:_____

(Note: UCF does not offer any form of health, liability, or other types of insurance for participants. Please attach a copy of the front and back of your insurance card with this form.)

Alternate person to contact:_____ Relationship:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone Number:_____ Alternate Phone Number:_____

Medical Information

Please list any current medical concerns or medical history we need to know about your child: (Ex. past injuries, current conditions, physical limitations, etc.)

_____

_____

List any allergies your child has: (Ex. medications, stings, food, iodine, latex, etc.)

List any medications your child is currently taking, the purpose, dosage, and times taken:

Does your child need any accommodations to safely participate in the program/activity? If yes, please explain:

Does your child require any assistance with his or her medications? If so, please explain:

Authorization for Medical Care

I understand that my child is voluntarily participating in a University of Central Florida Program/Activity. By signing this form I hereby acknowledge that all information is accurate and current, that any activity restrictions, allergies, and medications are listed on this form, and to the best of my knowledge, my child is capable of participating safely in the Program/Activity. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this Program/Activity. I agree to notify the Program/Activity of any changes in my child's mental, physical, or medical condition before the Program/Activity begins.

I understand that the University of Central Florida does NOT provide medical insurance for my child and that I am responsible for providing my own insurance. I should consult my child's physician before allowing my child to participate in this Program/Activity. In the case of accident or illness, I hereby authorize the Program/Activity staff to administer or seek medical treatment for my child, as they see fit, including routine first aid care or emergency medical treatment. I hereby agree to indemnify and hold harmless the Program/Activity, the University of Central Florida, the University of Central Florida Board of Trustees, the State of Florida and Florida Board of Governors and their respective employees, agents, officers, volunteers and servants from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment or other actions by UCF and its employees, agents, officers, volunteers and servants relating thereto. I acknowledge that I am solely responsible for any hospital, physician or other costs arising out of any bodily injury or property damage sustained by my child or through my child's participation in such voluntary Program/Activity.

Name of Participant:_____ Date:____/____/____

Signature of Parent or Guardian: _____

Parent or Guardian Name:_____