

To: Parent/s and Guardians of UWF's Explore Summer Programs Participants

In the next two forms is parental/guardian medical consent forms to be completed for participants in Organization-sponsored summer programs. This form was devised and approved by the University of West Florida's Office of the Organization's General Counsel.

Regardless of any similar statements that may be on your enrollment applications/registration forms, **these forms must also be completed.** Information is also attached regarding the coverage afforded by the Organization's insurance. Please note that the policy automatically renews annually.

Thank you for your cooperation.

UWF's General Counsel

**University of West Florida, Division of Continuing Education
Explore Summer Programs 2009**

CONTACT/MEDICAL INFORMATION

Participant: _____

Social Security Number: _____ Birthdate: _____

Parent(s)/Guardian(s) Names: _____/_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (____) _____

Parent(s)/Guardian(s) Work Telephone(s) (____) _____ (____) _____

Another Person to Contact in Case of Emergency: _____

Phone Number: (____) _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Company's Name: _____

Insured's Name: _____

Insured's Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Policy Number: _____ Fax Number: _____

Plan Type or Code Number: _____

MEDICAL INFORMATION

Use the following section to list allergies or medical conditions that might require special attention during the University of West Florida Explore Summer Camp Program. Examples include food, drug, or insect allergies; diabetes; chronic illness; recent surgery; and fainting spells. Include explanations for and dates of hospitalizations for any reason, list any prescribed medication that is taken regularly, and provide information about any special or psychological examinations, conditions, or treatments.

Allergies _____

Chronic Conditions (Asthma, etc.) _____

Regular Medications _____

Medical History _____

**University of West Florida, Division of Continuing Education
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MEDICAL AUTHORIZATION

PARENTAL CONSENT & AUTHORIZATION

We/I understand that our/my son/daughter _____, who is _____ years old and an academic-year student at _____, has been selected to attend the _____ (hereinafter "Program") to be held on the campus of _____ (hereinafter "Organization"), from _____ through _____, 20__.

We/I understand that my/our health insurance, if available, will be the primary coverage for _____ in the event of accident or illness while attending the Program. We/I further understand that in the event we/I do not have insurance or have exceeded our/my coverage limits, our/my son/daughter will be insured by the sponsors/administrators of the Program for accident and illness occurring during his/her attendance in the Program, excluding pre-existing medical conditions. This coverage is limited to a total amount of **\$25,000 accident medical benefits** per participant. The policy will be arranged through the Organization and will be in effect for the duration of the Program. Upon written request, a copy of the policy will be sent to parents or guardians when it is available. This coverage will be effective from the time the participants register until (**Camp Date** _____), excluding time away from the Program for holiday weekends, or at other times as approved by the Director or the Director's designee.

We/I also authorize the sponsors/administrators of the Program and authorized representatives of the Insuring Agency to obtain information regarding the medical history, physical condition, and diagnoses of our/my son/daughter, as required, for the purpose of documenting covered accidents/illnesses. A photocopy of this authorization shall be valid as the original. This authorization will be valid for the term of our/my son/daughter's coverage under the policy.

We/I, the parent(s) or guardian(s) of _____, do hereby request that the Organization, through its agents or employees, take whatever steps necessary to secure medical treatment for the child named above in the event such child appears to be in need of such treatment while attending the Program. We/I consent to the rendering of all necessary treatment, including admission to a hospital or other appropriate health care facility, in such institutions and at such places as the Organization, acting through its agents and/or employees, deems best. I authorize the agents and employees of the University to execute whatever forms might be necessary to ensure complete and adequate care of our/my child.

We/I affirm that the above medical information is complete and accurate. We understand that pre-existing health conditions are not covered by the Organization or by the Program's insurance and that such conditions are the financial responsibility of the parent(s) or guardian(s). We/I also understand that the insurance policy cited above does not cover any medical problems we/I have known about, or that we/I should have known about, and have not revealed to the Organization or the Program, and that certain conditions will not be covered under the terms of the insurance policy.

If this document is signed by only one parent:

"I, the undersigned, affirm that I have been judicially granted sole custody of the participant."

If this document is signed by a student's guardian(s):

"I/we, the undersigned, affirm that I/we have been judicially granted legal guardianship of the participant."

(optional)Student Participant Signature Date

Parent or Guardian Signature Date

(optional)Student Participant Signature Date

Parent or Guardian Signature Date

