



**Part 5: Medical Approval/Emergency Authorization – Please read both parts.**

**Note to Parent/Guardian:** If your child is under 18, we will make every reasonable attempt to contact you in the event your child incurs a medical emergency.

- **Parents/guardians of participants under the age of 18, please sign in the space provided.**
- **Students, if you will be 18 or older by May 29, 2009, please sign for yourself.**

In the event I cannot be reached, I hereby give permission for medical personnel to provide necessary emergency medical treatment to the student named below.

Student Name (printed): \_\_\_\_\_

Parent/Guardian Name (printed): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(If age 18 or older by May 29, 2009)*

If you wish to refuse emergency medical treatment for religious or other reasons, please provide an appropriate waiver of liability.

I understand and agree to abide by any medical restrictions placed on my activities while I am participating in the **Say YES to College** conference.

Student Printed Name: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART 6: STUDENT PARTICIPANT HEALTH AND MEDICAL HISTORY**

(Please contact Mary Beth Mueller at 757-253 4787 or e-mail [memueller@wm.edu](mailto:memueller@wm.edu) if a change in the student's health status occurs after these forms are sent to the **Say YES to College** committee.)

1. Does the student have any known allergies? (Food, medicine, plants, animals, insects, other)

\_\_\_ No \_\_\_ Yes If Yes, explain: \_\_\_\_\_

\_\_\_\_\_

2. Has the student ever experienced any of the following? [Circle all that apply]

Asthma      Bleeding disorders      Eating disorders      Seizures/Convulsions

Diabetes      Fainting spells      Depression      Other: \_\_\_\_\_

Please describe any condition you circled: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Is the student experiencing any current health problems?      \_\_\_ No      \_\_\_ Yes

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

4. Is there any reason that the student's participation in a program or activity should be restricted?  
 \_\_\_No \_\_\_Yes If Yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_
5. Is the student currently taking medications? \_\_\_Yes \_\_\_No **If Yes, also complete Part 7.**
6. What else should we know about the student? (Please include any concerns that may arise related to the child's physical, emotional, and/or social health in order that we may better provide appropriate supervision and support.) \_\_\_\_\_  
 \_\_\_\_\_

**PART 7: PLANS FOR ADMINISTERING MEDICATIONS**

Parents, if you are planning to attend **Say YES to College** you will be responsible for administering all medications your child needs. If you are not attending the **Say YES** conference a registered nurse will administer necessary medications. Please advise us of your intent by selecting Option A or B below.

\_\_\_ **Option A**

I am the parent/guardian of \_\_\_\_\_. I am attending **Say YES to College** and will be responsible for carrying and administering my child's medication/s.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_ **Option B**

I am the parent/guardian of \_\_\_\_\_. I do not plan to attend **Say YES to College** with my child. **I understand that I must sign the waiver that follows and provide all medical management information requested on pages 4 and 5. Further, if my child receives medication through an inhalant or injection process and self-administers these medications, I understand that I must provide documentation from my child's physician that my child is authorized to do so.**

**Permission to Administer Medication and Waiver/Release of all Claims**

I give permission for a registered nurse to collect, hold, and administer prescription and non-prescription medications to my child during **Say YES to College**. I understand that these medications must be packaged in the original container, appropriately marked, and given to the **Say YES to College** nurse during the check-in process. I further understand that the **Say YES to College** nurse is prohibited from administering any medication unless I provide all necessary instructions and meet all medication packaging guidelines. If my child uses an inhaler or receives medical injections and self-administers these medications, I understand that I must attach to this form documentation to this effect from the prescribing physician.

I hereby release the **Say YES to College** staff and committee members, Old Dominion University, The College of William and Mary, Norfolk State University, Tidewater Community College, participating disability service agencies, and all local education agencies from responsibility for accidental injury to my child.

Parent/Guardian (print): \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Listed below are medications I will bring for the *Say YES to College* nurse to collect, hold, and administer to my child:

➤ Name of medication: \_\_\_\_\_ Prescribed for the following condition:

\_\_\_\_\_

Dosage: \_\_\_\_\_ Method of administering: \_\_\_Oral \_\_\_Inhaler \_\_\_Injection

Schedule for administering this medication: \_\_\_\_\_

Storage information: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Special instructions for administering this medication: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

➤ Name of medication: \_\_\_\_\_ Prescribed for the following condition:

\_\_\_\_\_

Dosage: \_\_\_\_\_ Method of administering: \_\_\_Oral \_\_\_Inhaler \_\_\_Injection

Schedule for administering this medication: \_\_\_\_\_

Storage information: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Special instructions for administering this medication: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

➤ Name of medication: \_\_\_\_\_ Prescribed for the following condition:

\_\_\_\_\_

Dosage: \_\_\_\_\_ Method of administering: \_\_\_Oral \_\_\_Inhaler \_\_\_Injection

Schedule for administering this medication: \_\_\_\_\_

Storage information: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Special instructions for administering this medication: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

➤ Name of medication: \_\_\_\_\_ Prescribed for the following condition:

\_\_\_\_\_

Dosage: \_\_\_\_\_ Method of administering: \_\_\_Oral \_\_\_Inhaler \_\_\_Injection

Schedule for administering this medication: \_\_\_\_\_

Storage information: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Special instructions for administering this medication: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

➤ Name of medication: \_\_\_\_\_ Prescribed for the following condition:

\_\_\_\_\_

Dosage: \_\_\_\_\_ Method of administering: \_\_\_Oral \_\_\_Inhaler \_\_\_Injection

Schedule for administering this medication: \_\_\_\_\_

Storage information: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Special instructions for administering this medication: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

➤ Name of medication: \_\_\_\_\_ Prescribed for the following condition:

\_\_\_\_\_

Dosage: \_\_\_\_\_ Method of administering: \_\_\_Oral \_\_\_Inhaler \_\_\_Injection

Schedule for administering this medication: \_\_\_\_\_

Storage information: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Special instructions for administering this medication: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_