Camper's Name: ________________________________

Consent for Use of Medications

OWU Summer Music Camp-Ohio Wesleyan University

It is OWU Summer Music Camp's policy for you to turn all medications over to your child's counselor when you arrive at camp. The counselor will store and dispense medications to your child as directed below by you. ***Your child DOES NOT need a physical exam for OWU Summer Music Camp.***

Allergies/Reactions: ____
____
____
____

Date of last Tetanus Booster: ______________________________ (Required Information)
Month/Year

Existing illness or ongoing medical care: ____
____
____

Medications (name and frequency): ____
____
____
____

I give permission for my child to take the following over-the-counter drugs (check all applicable):

☐ Acetaminophen ☐ Antacid ☐ Aspirin ☐ Benadryl ☐ Ibuprofen ☐ Pepto Bismol

Other details related to helping your child with his/her mental or physical health during camp. (i.e., issues at home and/or school): ____
____
____
____

By signing below I do hereby authorize my child's counselor to hold and dispense the medications here listed to my child while at OWU Summer Music Camp. Telephone numbers where you can be reached including area codes:

Home: ____

Cell: ____

Work: ____

Signature of Parent/Guardian: ____

Date Signed: ____

Camper's Name: ________________________________ **Camper's Ensemble:** ________________________________

State law requires your consent for medical treatment and procedures as deemed necessary in case of an emergency.
Please read the form carefully and fill it in completely. Please ask about anything you do not understand.

Release and Waiver of Liability and Indemnification Agreement

Purpose: To release Ohio Wesleyan University from any and all liability for the claim(s) of a participating camper and/or the claim(s) of such camper's parents or legal guardian that might arise as a result of the camper's participation in the OWU Summer Music Camp and its programs and activities.

I/We understand that because of prohibitive costs, no accident, health, or life insurance covering the participants in this program will be procured and that my/our consent to the participation of the above-named participant in this program is made with this understanding. I/We recognize the possibility and risk of injury associated with my/our child's participation in the summer camp. In consideration of Ohio Wesleyan University's accepting my/our child as a registrant for and participant in the camp, as the parent/legal guardian of (***camper's name***) ____________________________________ date of birth: _______________,

I/we hereby release, discharge and/or otherwise indemnify Ohio Wesleyan University and agree not to seek or to hold Ohio Wesleyan University responsible, its agents, or employees from any claim(s) by or on behalf of the camper or myself/ourselves for injuries of any kind, including but not limited to those caused or allegedly caused by the negligence of Ohio Wesleyan University, its agents or its employees, as a result of or in connection with the camper's participation in the summer camp and its programs and activities.

Signature of Parent/Guardian:____ **Date:** __________________

Medical Authorization Form

Purpose: To enable parents or guardians to authorize medical and/or dental treatment for any participating camper who becomes ill or injured while in any program or activity in or related to the OWU Summer Music Camp when the parents or guardians cannot be reached.

As the parent or legal guardian of (***camper's name***) ____
date of birth: _______________________, I/we request that, in my/our absence, the above-named camper be admitted to any hospital or medical facility for diagnosis and treatment; and, I consent to such admission, diagnosis, and treatment. I/we request, consent to, and authorize physicians, dentist, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor and accept responsibility for the cost of the emergency services provided.

Physician:	Dentist:
Phone:	Phone:

Name of Parent/Guardian: ____

Address: ____

Person to be notified if parent/guardian is unavailable: ____

Phone (home) ______________________ (cell) _______________________ (work) ______________________

Insurance Carrier: _______________________________________ Policy Number: _________________________

Signature of Parent/Guardian: ____ Date: ___________________