HIGH SCHOOL TEENPOWER 2017
HEALTH HISTORY

FOR TEENPOWER PARTICIPANT, TO BE COMPLETED BY PARENT OR GUARDIAN

STUDENT NAME _____ **BIRTH DATE** _____ **AGE** _____ **GENDER: MALE FEMALE**

HOME ADDRESS _____
STREET & NUMBER CITY STATE ZIP

HOME PHONE _____ **GRADE (FALL 2017)** _____ **SCHOOL** _____

MOTHER'S NAME _____ **CELL PHONE** _____

FATHER'S NAME _____ **CELL PHONE** _____

PARENT'S EMAIL ADDRESS _____@_____

PARENTS WHO LIVE SEPARATELY CAN USE THIS LINE TO PROVIDE THE INFORMATION FOR (CIRCLE): MOTHER FATHER

HOME ADDRESS _____
STREET & NUMBER CITY STATE ZIP

IN CASE OF AN EMERGENCY, NOTIFY (SOMEONE OTHER THAN PARENT) _____

HOME PHONE _____ **CELL PHONE** _____ **RELATIONSHIP** _____

OPERATIONS OR SERIOUS INJURIES (DATES) _____

DISABILITY OR CHRONIC OR RECURRING ILLNESS _____

ACTIVITIES ENCOURAGED OR LIMITED BY PHYSICIAN _____

DIETARY MODIFICATIONS/KNOWN ALLERGIES _____

CURRENT MEDICATIONS _____

NAME OF DENTIST/ORTHODONTIST _____ **PHONE** _____

NAME OF FAMILY PHYSICIAN _____ **PHONE** _____

DATE OF PHYSICAL EXAMINATION _____

DO YOU CARRY FAMILY MEDICAL/HOSPITAL INSURANCE? _____ **YES** _____ **NO**

IF SO, INDICATE: CARRIER _____ **POLICY OR GROUP NUMBER** _____

ANY ADDITIONAL HEALTH RELATED INFORMATION _____

_____

THIS HEALTH HISTORY IS CURRENT SO FAR AS I KNOW, AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED TEENPOWER ACTIVITIES EXCEPT AS NOTED. AUTHORIZATION FOR TREATMENT: I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE PROGRAM COORDINATOR TO ORDER X-RAYS, ROUTINE TESTS, TREATMENT, AND NECESSARY TRANSPORTATION FOR MY SON OR DAUGHTER. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE PROGRAM COORDINATOR TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION, FOR MY SON OR DAUGHTER NAMED ABOVE. *EMERGENCY AUTHORIZATION VALID FROM JUNE 4, 2017-JUNE 8, 2017.*

SIGNATURE OF PARENT OR GUARDIAN _____
I ALSO UNDERSTAND AND AGREE TO ABIDE WITH ANY RESTRICTIONS PLACED ON MY TEENPOWER ACTIVITES.

SIGNATURE OF PARTICIPANT _____

HIGH SCHOOL TEENPOWER 2017
LIABILITY & PHOTO RELEASE

I understand that Youth Resources of Southwestern Indiana and the University of Evansville cannot assume any liability for people attending this event. I waive, release and discharge Youth Resources of Southwestern Indiana, Inc. and the University of Evansville from any and all claims of liability from my participation in this event. I also give permission for my picture to be used in any Youth Resources promotion and for my child to participate in TEENPOWER evaluations for the continuous improvement of the program.

ATTENDEE SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Youth Resources
PO Box 3635
Evansville, IN 47735-3635
812-421-0030
www.youth-resources.org

PERMISSION TO DISPENSE MEDICATION WAIVER

To be completed for prescription medications.
All medications must be turned in to Youth Resources at camp check-in.

STUDENT INFORMATION

First: ______________________ Middle: ______________________ Last: ______________________

Date of Birth (mm/dd/yyyy): _______________ Age: _______

MEDICATION TO BE TAKEN

Medication name: _______________________ Dosage (how much):__________ Refrigeration required: Y N

Note/instructions:____

____

____

Medication name: _______________________ Dosage (how much):__________ Refrigeration required: Y N

Note/instructions:____

____

____

Medication name: _______________________ Dosage (how much):__________ Refrigeration required: Y N

Note/instructions:____

____

____

STUDENT SELF-CARRY AND SELF-ADMINISTER MEDICATIONS

I acknowledge that my student can carry and self-administer emergency medication such as a rescue inhaler or insulin ONLY if the student has a written statement from their physician stating: 1) the student's chronic disease or condition requiring the medication, 2) the prescribed medication(s) and dosage 3) the physician's professional opinion that the student has been instructed on how to self-administer the medication and is capable of doing so, and that the nature of the student's disease or condition may require emergency administration of this medication. I agree to provide a statement that complies with this requirement if my child will need to self-carry and administer any medication(s).

NOTES

Written permission from the parent/guardian is required for all medication. In order to administer medication to your student, the following procedures must be followed:

- Prescription medications must be brought to TEENPOWER in the original pharmacy bottle. The label on the pharmacy bottle meets the requirements for the physician's signature. Prescription medication requires written permission (above) from the parent/guardian stating the amount of medication, the hours for administration, and the period of time that the medication is to be continued.
- Medications must be picked up at TEENPOWER check-out. Any medications left behind will be destroyed.

AUTHORIZATION

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in my absence, I hereby authorize Youth Resources of Southwestern Indiana and its TEENPOWER Adult Staff employees to administer to my child the above noted medication. I further acknowledge and agree that when the above medication is administered, I waive any claims I might have against Youth Resources of Southwestern Indiana and its staff arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Youth Resources of Southwestern Indiana and its staff, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication.

Printed name: _____

Signature: _____ Date: _____

Cell phone: _____ Work phone: _____

YOUTH RESOURCES OF SOUTHWESTERN INDIANA
MEDICATION ADMINISTRATION POLICY

Inevitably, some TEENPOWER participants will require medication while at TEENPOWER. The process for handling and administering medications must be well-structured and carefully followed in order to ensure the interests of the participant and the providers are best served. Both prescription and over-the-counter medications must be turned in at check-in and picked up at check-out. The parent/guardian must complete the attached form for any and all medications.

STAFF DOCUMENTATION

1. Staff giving medications to will document the time, date and dosage and route of the medication given on the child's Medication Administration Form and will sign each time a medication is given. Notation of failure to provide medication, at the prescribed time as requested by a physician or parent will also be noted.
2. Staff will report and document any observed side effects on the child's individual medication form.
3. Staff will provide a written explanation why a medication was not given.
4. *Medication authorization and documentation is considered confidential and must be stored out of general view.*

Medication errors will be controlled by checking the following six items each time medication is given:

- Right child
- Right medication
- Right time
- Right dosage
- Right route
- Right documentation

MEDICATION STORAGE

1. Medication will be stored as follows:
   - Inaccessible to TEENPOWER participant – controlled substances (i.e. Ritalin) will be stored in a locked location
   - Separate from staff or household medications
   - Protected from sources of contamination
   - Away from heat, light and sources of moisture
   - At temperature specified on the label (refrigerated if required)
   - So that internal (oral) and external (topical) medications are separated
   - Separate from food
   - In a sanitary and orderly manner

2. Medications remaining at the end of TEENPOWER will be picked up at check-out. Medications not claimed will be destroyed.

YOUTH RESOURCES
OF SOUTHWESTERN INDIANA

MEDICATION LOG

Student first & last name: _____

Student birth date (mm/dd/yyyy): _____

MEDICATION	DATE	TIME GIVEN	YOUR INITIALS	NOTES

REMEMBER

- Right child
- Right medication
- Right time
- Right dosage
- Right route
- Right documentation