

Penn State Event Participation Forms



PennState

Penn State Undergraduate
Admissions
201 Shields Building
University Park, PA 16802

Phone: 814-865-5471
Fax: 814-863-7590
Email: admissions@psu.edu

PARENT/GUARDIAN PERMISSION FORM

Name of Event: _____ Destination: _____

Event Date: _____ Bus Departure Location: _____
Date (mm/dd/yy)

You have been invited to an upcoming event or activity at Penn State. This event or activity will provide opportunities for you to experience all that Penn State has to offer from classroom experiences and residence halls to dining facilities and beyond. Spaces are limited and requests are filled on a first-come, first-served basis. Your registration is not guaranteed until you receive a confirmation.

1. Print the Permission form
2. If Applicable, print the Medication Management Authorization Addendum
3. Complete the information on the form - all fields are required unless otherwise marked!
4. Get required signatures
5. Fax to 814-863-7590

This form must be completed and returned before Penn State event enrollment dates in order for the student to be permitted to participate in any event activities.

Personal Information

First Name/ Student: _____ Last Name/Student: _____

Birthdate _____ E-mail Address: _____ M F

Address _____ City _____

State _____ Zip _____ Home Phone: _____

Parent/Guardian #1 _____ Parent/Guardian #2 _____

Daytime Phone: _____ Daytime Phone: _____

If neither parent nor guardian is available in an emergency, please contact:

1. _____ Phone: _____

2. _____ Phone: _____

Name of Family Physician: _____ Phone: _____

Will the student need to take any medication during the program? NO Yes (if yes, please see addendum)

Does the student have any allergies? NO Yes If YES, explain: _____

Is there anything else in student's health history that the program staff should know? _____

I, the undersigned, as a parent and/or guardian of the above named student give permission for him/her to participate in this event or activity sponsored by Penn State. In consideration of such permission, I do hereby agree to release, discharge, and hold harmless Penn State, its officers, agents, and employees of and from all causes, liabilities damages, claims, or demands whatsoever on account of any injury or accident involving the said prospective student arising out of the student's attendance at the event or in the course of activities associated with the event.

Student's Last Name: _____ First Name: _____

Birthdate: _____ M F

I authorize do not authorize (check one) Penn State to photograph, videotape, and/or audio- tape my child in promotion of the University or the event. In giving this consent, I release Penn State from responsibility for any violation of personal or proprietary right I have in connection with this use.

My child and I understand that all University regulations must be followed.

I hereby authorize the clinical staff of University Health Services or other licensed practitioner of the healing arts, acting within the scope of his or her practice under State law, to provide medical care that includes routine diagnostic procedures (e.g., x-rays, blood and urine tests) and medical treatment as necessary to my minor daughter/ son/dependent. I understand that the consent and authorization herein granted does not include major surgical procedures and are valid only during the Student Program/event.

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and if I cannot be reached, I give my consent for physicians and staff at University Health Services or other licensed practitioners of the healing arts to perform any necessary emergency treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. I understand that University Health Services does charge for services and that it is my responsibility to pay the bill if a claim can't be submitted by the University Health Services to my private insurance. As applicable, I may be responsible to submit any claims to my health insurance company for reimbursement. I authorize The Pennsylvania State University to receive medical/billing information and submit it to the University's insurance carrier.

I understand that, unless specifically stated otherwise in the Penn State Student Program/event literature, The Pennsylvania State University does not provide medical insurance to cover emergency care or medical treatment of my child.

I understand that, in accordance with Student Program policy, the medication(s) should be given at home before and/or after the Student Program. However, when this is not possible, and medications will be brought to Student Program, I agree to the provisions outlined in the Medication Management Authorization Addendum relating to the management of medications.

HIPAA

Penn State honors the privacy of the participants in its Programs and complies with the national regulations regarding health information. Follow this computer link to the University Health Services Notice of Privacy Practices.

<http://studentaffairs.psu.edu/health/welcome/confidentiality/noticeOfPrivacyPractices.shtml>

Parent/Legal Guardian's: _____
(First Name/Parent) (Last Name/Parent)

Parent's/Legal Guardian's Signature: _____

SCHOOL PERMISSION

Name of High School: _____

Name of High School Counselor: _____

Student's GPA: _____

Counselor Signature: _____

Student Signature: _____

Date (mm/dd/yy): _____

Medication Management Authorization Addendum

To be completed only if medication is needed during the program day

Student's Last Name: _____ First Name: _____
Birthdate _____ M F

If at all possible, medication should be administered at home. Medications will be allowed at the Student Program only when failure to take such medicine would jeopardize the health of a child and he/she would not be able to attend the Student Program if the medicine were not made available.

The parent(s)/legal guardian(s) of Student Program participants are required to disclose their intention to bring medications to the Program, especially to treat potentially life-threatening conditions (i.e. inhalers, EPI-pens, insulin injections). Upon arrival to the Program, parent(s)/legal guardian(s) should plan to meet with a member of the Student Program staff at registration to review medication issues for a Student Program participant and complete additional required paperwork if not completed prior to arrival. For identification purposes, a current picture of the child is to be provided upon registration.

All medications (prescription and over-the-counter) must be stored in the original product packaging and clearly labeled with the participant's name. Prescription medication(s) must also include a label with the medication's name and dosage instructions, as well as the prescribing physician's name and telephone number.

All medications will be kept in a securely locked cabinet used exclusively for storage of medications. Medications that require refrigeration will be stored and locked in a refrigerator designated for medications **ONLY**. Access to all medications will be limited to approved personnel. The need for emergency medication may require that a Student Program participant carry the medication on his/her person or that it be easily accessed (i.e. inhalers, EPI-pens, insulin injections). Penn State Student Program staff will **NOT** purchase medications of any type (prescription or over-the-counter) for Student Program participants of any age.

If a Program has professional medical staff on-site, then the medical staff may administer over the counter medications (e.g., ibuprofen or Tylenol) supplied by the parent(s)/guardian(s) per package instructions. Medical staff may monitor the self-administration of medications, if necessary, upon written consent of the parent(s) and/or legal guardian(s) and/or physician orders.

If there are no medical staff on-site, Penn State Student Program staff will not dispense medications, but may monitor the self-administration of certain medications if necessary, **ONLY** upon written consent of the parent(s)/legal guardian(s) and /or physician's orders.

It is NOT permissible for a participant to share any medications with any other participants.

It is the responsibility of the parent(s)/legal guardian(s) to be sure that the participant's medications brought to the Student Program are not left behind at the end of the Program. Failure to do so will result in the medications being destroyed within three working days after the participant's last day at the Program. Absolutely no medications will be returned via mail regardless of circumstance.

Please complete the information on the following page as appropriate (Please, no abbreviations).

Student's Last Name: _____ First Name: _____
Birthdate _____ M F

Yes, non-prescription over-the-counter medications/are being brought to the Penn State event. Please indicate the name of the medication dosage and reason for the medications.

Medication:
Dosage(s):
Reason(s):

Please notify us that non-prescription over-the-counter medication will be self-administered by checking here

Yes, prescription medication is/are being brought to the Penn State event. Please indicate the name of the medication dosage and reason for the medication.

Medication Prescribing Physician(s):
Prescribing Physician(s) Telephone Number(s):
Dosage(s):
Reason(s):

If prescription medication will be self-administered please check here

If your child may require assistance with the administration of prescription medication for a potential medical emergency please check here ____ and provide special instruction below.

Special Instructions:

It is understood that medication are managed, if necessary and in an assistive manner only, solely at the request of and as an accommodation to the undersigned parent or legal guardian. In consideration of the acceptance of the request to perform this service by any person employed by Penn State, the undersigned parent or legal guardian hereby agrees to defend, indemnify, and hold harmless the Trustees of The Pennsylvania State University, its trustees, officers, agents, employees and students from any and all claims which they now have or may thereafter have arising out of the assistance of or failure to assist with medication to the respective program participant.

Parent/Legal Guardian Signature: _____ Phone Number: _____

Date: _____