TEXAS A&M AGRILIFE EXTENSION

Authorization to Dispense Medication

ADM 09.01.2020

Participant: _____ **Food Allergy (if applicable):** _____ **Medication** *(Listed Below)*

All medication to be administered must comply with the following guidelines:

1. All medication, including over-the-counter, must be in the **original container**. All prescription medication must be in the participant's name. Sharing of prescription medication is not allowed. Inhalers must be accompanied by the prescription label.
2. All medication must be accompanied by this dated medication authorization form signed by the parent / legal guardian.
3. Please include instructions for over the counter medications.
4. **All medication, including over-the-counter, will be given ONLY as directed on the label.**
5. If there has been a change in the dosage, please send a note from the participant's doctor reflecting the change.

List all medications your child will be taking. **Prescriptions will be given as directed on the label.**

Medication	Dosage	Time to be given	Special instructions	Staff use only, please do not write here.						

By signing below, I certify that the information is true and complete. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

Parent/Guardian Name _____

Parent/Guardian Signature _____ **Date** _____

TEXAS A&M AGRILIFE EXTENSION

HSS 09.01.2020

Texas 4-H Youth Development Program
HEALTH AND SAFETY STATEMENT

Check one: ___ Youth ___ Adult **County:** _____ **District:** _____

Event: _____ **Event Dates:** _____

Section I. Participant Information

First Name: _____ **Date of Birth:** _____ **Age:** _____ **Gender:** _____

Last Name: _____ **Name of Physician:** _____

Address: _____ **Physician's Number:** _____

City, State, Zip: _____ **Date of last physical exam:** _____

Phone: _____

Section II. Emergency Contact Information

Name: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

City, State, Zip: _____ **Cell Phone:** _____

Section III. Health History *(Check the appropriate answer and explain any YES responses.)*

Have you had or do you currently have any heart problems? Dates: _____ ___ Yes ___ No

Do you frequently suffer from pains in your chest? _____ ___ Yes ___ No

(NOTE: If you have any heart related problems you will need to have a physician's release.)

Do you often feel faint or have spells of severe dizziness? _____ ___ Yes ___ No

Has a doctor ever told you that you might have high blood pressure? _____ ___ Yes ___ No

Are you a smoker? _____ ___ Yes ___ No

Do you have arthritis, joint, or back problems that can be aggravated by exercise? _____ ___ Yes ___ No

Have you had any operations or serious injuries? Dates: _____ ___ Yes ___ No

Do you have any chronic recurring illness or communicable diseases? _____ ___ Yes ___ No

Are there any activities to be limited/discouraged by a physician's advice? _____ ___ Yes ___ No

Are you allergic to any medications, food or food ingredients, insects, or pollens? _____ ___ Yes ___ No

Do you have Epilepsy? _____ ___ Yes ___ No

Do you have Diabetes? _____ ___ Yes ___ No

Do you have any prescribed meal plan or dietary restrictions? _____ ___ Yes ___ No

Any other health related information for 4-H personnel to be aware of? _____ ___ Yes ___ No

Section IV: Medications *(ALL medications must be in ORIGINAL container with ORIGINAL LABEL.)*

Are there prescribed or over-the-counter medications currently being taken? Describe. _____ ___ Yes ___ No

Section V. Insurance Information – *Please provide a copy of your insurance card.*

Do you carry family medical/hospital insurance? ___ Yes ___ No

Carrier: _____ Policy Number: _____

Section VI. Release of Participant *(If minor)*

I/We do hereby authorize the release of said minor child to the following person/people at the conclusion:
(please list all persons, including parents)

_____ _____

Further, I/We require that said minor child NOT be released to the following person/people at the conclusion of the activity:

_____

Section VII. Health and Safety Statement Certification

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

Participant OR Parent/Guardian Name (if participant is under the age of 18): _____

Parent/Guardian Signature: _____ **Date:** _____

TEXAS A&M AGRILIFE EXTENSION

OTC 09.01.2020

Parent Guardian Authorization, Waiver, & Consent for Over-the-Counter Medication

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the youth's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during her/his stay. Note: Unless we have parental authorization, we cannot administer ANY medications.

Participant Name _____

Date of Birth _____ **Age** _____ **County** _____ **District** _____

Name of Event Attending _____ **Event Date(s)** _____

Please check the OTC medications that may be administered while your child is attending the event, if needed.

	Ointments for minor wound care, first aid (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn) as directed.		Milk of Magnesia, Pepto Bismol, or Mylanta for upset stomach or nausea as directed.
	Tylenol/Acetaminophen as directed		Calamine lotion for bug bites and poison ivy
	Ibuprofen as directed		Micatin or anti-fungus treatment as directed for athlete's foot
	Kaopectate or Imodium for diarrhea as directed		Visine or other eye drops for minor eye irritation
	Rolaids or Tums for acid reflux, heartburn, or indigestion as directed		Actifed or Sudafed as directed for nasal congestion or allergy relief as directed
	Benadryl for swelling, hives, allergic reaction, as directed		Throat lozenges and/or spray as directed for sore throat
	Medicated powder for skin irritation as directed		Swimmer's ear drops as directed
	Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites		Bug repellent
	Robitussin or other cough syrup as directed		Sunscreen
	Other (list any other approved OTC drugs):		

Program staff reserve the right to use generic equivalents when available for the name brand over-the-counter medications listed above. I understand that such administration will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed. I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the student's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless for any all purposes program staff, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas A&M University, Texas A&M AgriLife Extension, the Texas 4-H Youth Development Program and their members, officers, servants, agents, volunteers, or employees (RELEASEES) against any claims that may arise relating to my child being administered the above indicated over-the-counter medications ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, intentional torts, or strict liability of RELEASEES***.

I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the program hosted by/at Texas A&M AgriLife Extension.

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____

Adaptedfrom Auburn University's Summer Experience Required Form Packet, http://www.auburn.edu/student_info/auband/event/summer_camps/documents/2014_medical_form.pdf

TEXAS A&M AGRILIFE EXTENSION

SAP 09.01.2020

Parent Guardian Authorization, Waiver, & Consent for Self-Administration of Prescription Medication – Participants 15 years of age or older

This portion of the form must be completed fully in order for participants to self-administer required medication. This form must be completed for each camp/program attended by the youth, for all medications, and each time there is a change in dosage or time of administration of a medication. Program Managers reserve the discretion to use this form.

Participant Name _____

Date of Birth _____ **Age** _____ **County** _____ **District** _____

Name of Event Attending _____ **Event Date(s)** _____

☐ No, my child does not need to take any prescription medication while at the program.

☐ Yes, my child will need to take prescription medication while at the program.

All prescription medications, including medications for conditions such as food, drug or insect allergies, diabetes; asthma; or epilepsy may be brought to the program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so at program by a parent/legal guardian. Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the youth will be attending the program.

Medication Name: _____ Dose: _____

Specific Directions (i.e. on empty stomach, with water, etc.) _____

_____

Time/Frequency of administration: _____

Relevant side effects: _____

Special Storage Requirements (if any): _____

Is the participant capable of self-managed care? ☐ Yes ☐ No

Prescribing Physician: _____

Telephone of Physician: _____

I authorize and recommend self-medication by my child for the above medication. I also affirm that s/he has been instructed in the proper self-administration of the prescribed medication(s) by her/his attending physician. I agree to indemnify and hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas A&M University, Texas A&M AgriLife Extension, the Texas 4-H Youth Development Program and their members, officers, servants, agents, volunteers, or employees against any claims that may arise relating to my child's self-administration of prescribed medication(s) ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, intentional torts, or strict liability of RELEASEES.***

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____

Adaptedfrom Auburn University's Summer Experience Required Form Packet, http://www.auburn.edu/student_info/auband/event/summer_camps/documents/2014_medical_form.pdf

2023-2024 TEXAS 4-H YOUTH DEVELOPMENT PROGRAM

Program Name

CAMP & ENRICHMENT PROGRAM
WAIVER, INDEMNIFICATION, AND MEDICAL TREATMENT AUTHORIZATION FORM

1. EXCULPATORY CLAUSE. In consideration for receiving permission to participate in any and all activities of Texas 4-H ("activity"), which is sponsored by Texas A&M AgriLife Extension Service and Texas 4-H Youth Development Program, ("sponsor"), a member of The Texas A&M University System, I hereby release, waive, covenant not to sue, and agree to hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for The Texas A&M University System, and their members, officers, agents, volunteers, or employees ("RELEASEES" or "INDEMNITEES") from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in this activity, while traveling to and from the activity, or while on the premises owned, leased, or controlled by RELEASEES, **including injuries sustained as a result of the sole, joint, or concurrent negligence, gross negligence, negligence per se, statutory fault, intentional torts, or strict liability of RELEASEES.**

2. INDEMNITY CLAUSE. I am fully aware that there are inherent risks to myself and others involved with this activity, including but not limited to all events and activities, and I choose to voluntarily participate in this activity with full knowledge that the activity may be hazardous to me and my property, and to the person and property of others. I acknowledge there may be physically strenuous activities. I know of no medical reason why I should not participate. **I agree to indemnify and hold harmless INDEMNITEES** from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, which may occur to myself, other participants, and third-persons as a result of my participation and conduct in this activity**, including injuries sustained as a result of the sole, joint, or concurrent negligence, gross negligence, negligence per se, statutory fault, intentional torts, or strict liability of INDEMNITEES.**

3. COVID-19. I expressly acknowledge the health risks and dangers associated with the transmission of the COVID-19 virus, and other communicable diseases, and recognize that exposure to the COVID-19 virus, or other communicable diseases, could occur while my child is in the care of sponsor. As such, and as additional consideration for participation in the activity, I understand the waiver and indemnity provisions in paragraphs (1) and (2) above apply to the possibility of COVID-19 community spread. I certify that prior to leaving my child in the care of the sponsor that my child: (a) has not been diagnosed or is suspected to have COVID 19, (b) does not have any of the coronavirus symptoms listed on the CDC's Symptoms of Coronavirus page, (c) has not in the past 14 days had close contact (less than six feet) with a person who has a lab-confirmed case of COVID-19, (d) has not in the past 14 days had close (less than six feet) contact with a person who is awaiting results of a COVID-19 test because of COVID-19 symptoms or exposure, or (e) in the past 14 days has not returned from international travel or traveled through an area with state or local restrictions that mandate quarantine upon arrival home. I also certify that each time I leave my child in the care of the sponsor, I have conducted a daily assessment on my child and that he/she is not exhibiting any of the above signs or symptoms of, or exposure to, COVID-19.

4. NO INSURANCE. I understand that RELEASEES do not maintain any insurance policy covering any circumstance arising from my participation in this activity or any event related to that participation. As such, I am aware that I should review my personal insurance coverage. Sponsor does not carry general liability insurance to cover claims arising from this activity so it seeks a waiver of claims as additional consideration for the right to participate so sponsor, a governmental unit of the State of Texas, can(a) provide the activity at the lowest possible cost to participants; and (b) provide access to a greater number of participants by expending limited resources on program materials rather than on liability insurance.

5. BINDS HEIRS. It is my express intent that this agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be governed by the laws of the State of Texas.

6. MEDICAL AUTHORIZATION, INDEMNITY FOR MEDICAL EXPENSES, and WAIVER. I understand RELEASEES cannot be expected to control all of the risks associated with this activity and RELEASEES may need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required, as determined by a medical professional at the medical facility, during my participation in this activity with the understanding that the cost of any such treatment will be my responsibility. I agree to indemnify and hold harmless INDEMNITEES for any costs incurred to treat me, even if an INDEMNITEE has signed hospital documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, covenant not to sue, and agree to hold harmless for any and all purposes, RELEASEES from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, gross negligence, statutory fault, intentional torts, or strict liability of RELEASEES.**

7. NO STRICT RULES OF CONSTRUCTION. In the event of a dispute over the meaning or application of this agreement, it shall be construed fairly and reasonably and neither more strongly for nor against either party.

8. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; sponsor has not made and I have not relied on any oral representations, statements, or inducements apart from the terms contained in this agreement. I execute this document for full, adequate and complete consideration fully intending to be bound by the same, now and in the future. **For youth engaging in extracurricular activities**: I understand I can choose not to sign this document and free myself from its terms and the associated risks of the activity by simply not participating in the activity and choosing some other activity available to me that has a lower level of risk to me. I further understand this is a voluntary, extracurricular activity.

SIGNING THIS DOCUMENT INVOLVES THE WAIVER OF VALUABLE LEGAL RIGHTS.
CONSULT YOUR ATTORNEY BEFORE SIGNING THIS DOCUMENT.

In case of emergency, contact: _____

At the following number: _____

If the participant has medical insurance, please indicate: _____

Insurance Company: _____ **Policy Number:** _____

Name of Primary Policy Holder: _____

Please list any special service your child may require: _____

_____

_____

SIGNED this _____ day of _____ ,20 _____

Participant Signature: _____

Printed Name: _____

Participant's Date of Birth: _____

Parent or Legal Guardian Signature:
(If participant is under 18 years old) _____

Parent or Legal Guardian Printed Name:
(If participant is under 18 years old) _____