

## UNIVERSITY OF CENTRAL FLORIDA

## Youth Protection Program Medical Information and Authorization for Medical Care

Program/Activity Name			
Today's Date: / /			
Basic Personal Information (pleas	se print)		
Child's Name:			
Address:			
City:		State:	_Zip:
Phone Number:		Alternate Phone Number:	
Date of Birth:	_Height: _	Weig	ght:
Emergency Contact Information			
Person to contact in case of emerg	gency:		_Relationship:
Address:			
City:		State:	_Zip:
Phone Number:		Alternate Phone Number:_	
Family Physician:		Phone Number:	
Insurance Provider:		Phone Number:	
Insurance subscriber name:			
Group Number:		Policy Number:	
(Note: UCF does not offer any form of health, and back of your insurance card with this for		ther types of insurance for particip	ants. Please attach a copy of the front
Alternate person to contact:			_ Relationship:
Address:			
City:		State:	_Zip:
Phone Number:		Alternate Phone Number:_	
Medical Information			
Please list any current medical copast injuries, current conditions, p			o know about your child: (Ex.
-			-

List any allergies your child has: (Ex. medications, stings, food	, iodine, latex, etc.	)	
List any medications your child is currently taking, the purpos	e, dosage, and tim	es taker	1:
Does your child need any accommodations to safely participat please explain:	e in the program/	activity	? If yes,
Does your child require any assistance with his or her medicat	cions? If so, please	e explair	1:
Authorization for Medical Care  I understand that my child is voluntarily participating in a Uni Program/Activity. By signing this form I hereby acknowledge current, that any activity restrictions, allergies, and medication best of my knowledge, my child is capable of participating safe acknowledge that my failure to disclose relevant information others during this Program/Activity. I agree to notify the Programid's mental, physical, or medical condition before the Programid and that I am responsible for providing my own insurance physician before allowing my child to participate in this Programidless, I hereby authorize the Program/Activity staff to admin my child, as they see fit, including routine first aid care or eme agree to indemnify and hold harmless the Program/Activity, tuniversity of Central Florida Board of Trustees, the State of Florida their respective employees, agents, officers, volunteers an action, damages, and/or liabilities arising out of or resulting fired.	that all informations are listed on the ly in the Program may result in harmam/Activity of an am/Activity beging the Lister or seek medical tracks and Florida and Florida and servants from a lister on a lister of Corida and Florida an	on is accomis form, Activity on to my changes.  surance lt my chee case of ical treatment entral F Board of any clain	and to the y. I child and/or ges in my ild's faccident or tment for t. I hereby florida, the f Governors ns, causes of
actions by UCF and its employees, agents, officers, volunteers acknowledge that I am solely responsible for any hospital, phy any bodily injury or property damage sustained by my child of such voluntary Program/Activity.	and servants relat vsician or other co	ing ther sts arisi	eto. I ng out of
Name of Participant:	Date:		
Signature of Parent or Guardian:			

Parent or Guardian Name: