2024 Eno Arts Mill Summer Camp Supplemental Form Questionnaire

Insurance Information (required)

Policy Number_____

Name of Health Insurance Provider_____

Primary Physician_____

Address_____

Physician Phone_____

Hospital Preference_____

Medical emergency contact: (required)

	Name	Phone Number	Relationship to Child
Contact #1			
Contact #2			
Contact #3			

Medical Release (required)

This is to certify that I (participant above), or parent of above participant in the Orange County Arts Commission (OCAC), Orange County Arts Commission (OCAA), Eno Arts Mill (EAM) activity, hereby grant permission to the adult volunteer or supervisor of the program to obtain medical care from any licensed physician, hospital, or medical clinic for the participant named herein at such times as either parent, legal guardian, or emergency contact cannot be contacted in person or by telephone. This authorization shall include all activities, including the period required to travel to and from those activities; and we do hereby waive, release, absolve, indemnify and agree to hold harmless OCAC, OCAA, EAM , any sponsoring agent and any volunteer; the organizers, supervisors, participants, and person transporting the player to and from those activities, for any claim arising out of any injury to the participant.

I understand that I will be notified in the case of a medical emergency involving my child. In the event that I cannot be reached, I authorize calling a doctor and the providing of necessary medical services in the event my child is injured or becomes ill.

Parent's/Guardian's Initials _____

I understand that OCAC will not be responsible for the medical expenses incurred, but that such expenses will be my responsibility as parent/guardian.

Parent's/Guardian's Initials _____

ADMINISTRATION OF MEDICATIONS TO PARTICIPANTS POLICY

It is our intent that everyone may participate in Orange County Arts Commission (OCAC), Orange County Arts Alliance (OCAA), Eno Arts Mill (EAM) programs regardless of whether a participant requires ongoing medication prescribed by a physician. Staff does not as a matter of routine administer medications, however will in limited medically necessary circumstances. Every effort should be made by the parent/guardian to administer medications prior to or after program hours. If your child requires medication(s) during a scheduled program, please read through the attached information, complete the attached ADMINISTRATION OF MEDICATION CONSENT FORM, and return to OCAC, OCAA, EAM before the first day of camp. The following information is to provide criteria and direction regarding the medical responsibilities for participants of OCAC, OCAA, EAM programs:

1. The parent/guardian will make every effort to administer medications prior to or after program hours.
2. It is understood that OCAC, OCAA, EAM staff and volunteers are not required to have medical training. Their supervision of medications is limited to that of seeing that participants get proper medications as prescribed, in a timely and supervised manner.
3. Medications WILL NOT be administered without the signed and properly completed Administration of Medication Request and Consent Form to include specific dosage times of prescription medication.
4. Medication may be administered to participants who:
   A. Take regularly scheduled oral prescription medications.
   B. Take doctor-prescribed over-the-counter medications.
   C. Need medications readily available such as Epi-pens, asthmatic inhalers, and prescription medicines.
5. Department staff and volunteers WILL NOT be permitted to do the following:
   A. Administer needle injections (such as those for insulin) of any type, with the exception of an Epi-pen or "auto injectors".
   B. Dispense "over-the-counter" medications (such as Tylenol, Benadryl, etc.) unless they have been prescribed by a licensed physician showing scheduled time and dosage.
6. Medications:
   A. All medications must be in their original labeled containers with clear instructions of scheduled time and dosage (pharmacist may provide a second labeled container). A general statement such as 'take in AM or PM' will not be accepted; specific times are required.
   B. If a medication requires a measuring device (cup, spoon, etc.) for proper dosage, it must be provided with the medication and include the participant's name and home phone number on it. Pills that are to be split and given as half-doses must be provided as such.
   C. Provide only the amount of medication necessary for the program session.
   D. Over-the-counter medications must be accompanied by written doctor's instructions, and signed by a licensed physician with dosage and specific times.
7. Transfer of medications:
   A. The transfer of all medications will be documented, both into and out of staff control. Confirmation of medication name and quantity will also be documented.
   B. If medications are transferred into staff control for the duration of a program, and medication remains at the end of the program, the parent/guardian must pick up the medication within one week of the end of the program. Medications left unclaimed after one week will be destroyed.
8. On-site medication storage:
   A. Medications will be stored in a secure area that is accessible only to authorized staff persons.
   B. OCAC, OCAA, EAM cannot guarantee refrigeration for medication at the program site. Medications requiring refrigeration should be packed in a non-breakable cooler with sufficient ice to keep the medication cold for the duration of the program day, and for travel away from the program site, if applicable.
   C. If participants travel off-site as part of the program, their medication will be kept in the possession of a staff member at all times.
9. Any changes in medications, dose, administration or conditions under which medications are administered require a new ADMINISTRATION OF MEDICATION CONSENT FORM be completed.
10. Recreation Supervisors are responsible for implementing this policy for their program, fully training staff in the policy and procedures and for all documentation and archiving for three years.

ADMINISTRATION OF MEDICATION CONSENT FORM

PLEASE PRINT ALL INOFRMATION IN INK

Participant's Name: _____ Current age: _____

Parent/guardian's name: _____ Home Phone #: _____

Work Phone #: _____ Cell Phone #: _____

Parent/guardian's name: _____ Home Phone #: _____

Work Phone #: _____ Cell Phone #: _____

Physician's Name: _____ Office Phone #: _____

AUTHORIZATION FOR MEDICATION

Medication name: _____ Condition: _____

Dosage and schedule during program hours: _____

Special instructions: _____

Side effects: _____

Medication name: _____ Condition: _____

Dosage and schedule during program hours: _____

Special instructions: _____

Side effects: _____

Medication name: _____ Condition: _____

Dosage and schedule during program hours: _____

Special instructions: _____

Side effects: _____

CONSENT

I, _____, (parent/guardian name), having read the ADMINISTRATION OF MEDICATIONS TO PARTICIPANTS POLICY, give my consent for OCAC, OCAA, EAM staff to administer the above medication to _____ (child/participant), according to the directions provided on the medication label and/or by my child's physician. The above information is correct to the best of my knowledge.

_____ _____

Parent/guardian signature Date

The above information is approved by attending Medical Physician. ***Signature required for non-prescription medications only**

_____ _____

Physician's signature Date