PERMISSION AND CERTIFICATION

I, the undersigned, hereby give my permission for my son/daughter to participate in all the activities of the _______ (insert program name) Program at UMass Boston from the date of his/her acceptance throughout his/her involvement with the program.

We (youth and I) agree to support the administrative rules of the __________________ (insert program name) Program, the below referenced UMass Boston policies and guidelines, and to cooperate with the staff to our fullest extent.

Further, by signing below, I attest to the fact that all of the information provided by me or any other person on this application is true and complete to the best of my knowledge.

<table>
<thead>
<tr>
<th>Signature of Parent/Guardian</th>
<th>Printed Name</th>
<th>Date</th>
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POLICIES AND GUIDELINES

PERMISSION TO PARTICIPATE When you signed your child’s medical form, you gave permission for your child to participate in all program activities. If you wish for your child to be restricted from any activity, please notify us in writing prior to your child’s program session. Please note that it is not our policy to force any child to participate in an activity. We do our best to make the activity enjoyable so your child will wish to participate.

MEDICAL CONCERNS All program participants under the age of 18 are required to have a completed packet including UMass Boston’s health history, immunizations, consent to treat minor patient, and authorization to administer medication forms on file before the program begins. Please be sure that you complete these forms and that your child’s healthcare provider has signed that a physical examination has been conducted within the last 24 months. Please provide us with as much information as possible concerning your child’s medical history, allergies, medications, and any special needs. All medical forms must include an up-to-date immunization record and must be signed by a healthcare provider.

MEDICATION Every effort should be made to administer routine medications at home in order to prevent disruption in your child’s daily program activities. However, if your healthcare provider believes that it is in the best medical interest of your child to administer them during the program’s hours, please submit the completed Authorization to Administer Medication form. A separate form must be completed for each medication. State law does not permit administration of medication during the program hours without written authority by the prescribing healthcare provider. Youth program staff who are under the age of 18 are at no time allowed to carry any kind of medication, be administered medication without official written directive from the prescribing healthcare provider, or take medication without direct youth program supervision.

SAFETY PROCEDURES Whenever possible, we bring outdoor activities into air-conditioned facilities, or to cool, shaded areas. Our first concern is for your child’s safety; therefore, we reserve the right to take the following actions in very hot weather: reduce physical activities, substitute outdoor activities for sedentary activities, and provide activities unrelated to your child’s specialty (e.g., movies).

MEDICAL NOTIFICATION It is our policy to notify you if your child becomes ill during the youth program or suffers an injury other than minor bumps, bruises or scrapes.

VALUABLES We recommend that program staff not bring large sums of money or other valuables to UMass
Boston. The University is not responsible for lost or stolen personal items.

**SUNSCREEN** The use of sunscreen is highly recommended by University Health Services. It is best to apply sunscreen to your child before he or she leaves home in the morning. You may wish to send along additional sunscreen to be applied later in the day.

**INAPPROPRIATE BEHAVIOR** UMass Boston reserves the right to dismiss any participant who acts in an inappropriate or detrimental manner including bullying, harassing, intimidating, or threatening to other individuals.

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### PERSONAL, FAMILY, AND EMERGENCY CONTACT INFORMATION

Name of youth (first & last): ____________________________________________

__________________________________
Street Address                Apt. #

__________________________________
City      State    Zip Code

Youth’s Cell Phone # (if applicable): ________________________________________

Youth’s Date of Birth: ____________________ Youth’s Gender: male_____ female____

Name of School: _____________________________ Youth’s Grade: ______________________

Language Spoken at Home: __________________ Hair Color: ____________________________

Eye Color: ______________________________ Height: ________________________________

Weight: ____________________________ Can the youth swim? Yes_____ No____

Parent/Guardian Name (first & last): ____________________________________________

__________________________________
Street Address                Apt. #

__________________________________
City      State    Zip Code

Home Phone #: __________________________ Work Phone #:_________________________

Cell Phone #: _________________________
**Emergency Contact #1**  
Check here if same as parent/guardian: _______

Name (first & last): ___________________________________________________________

_____________________________________________________________________________

Street Address                                          Apt. #

_____________________________________________________________________________

City                      State                 Zip Code

Home Phone #:             Work Phone #:         ________________________________

Cell Phone #:             ________________________________

Relationship to Youth: _______________________________________________________


**Emergency Contact #2**

Name (first & last): __________________________________________________________

_____________________________________________________________________________

Street Address                                          Apt. #

_____________________________________________________________________________

City                      State                 Zip Code

Home Phone #:             Work Phone #:         ________________________________

Cell Phone #:             ________________________________

Relationship to Youth: _______________________________________________________

________________________

Signature of Parent/Guardian          Printed Name          Date
RELEASE FORMS

PLEASE READ THE FOLLOWING RELEASES CAREFULLY AND PROVIDE A SIGNATURE FOR EACH SECTION BELOW.

GENERAL RELEASE

I, ________________________________, (parent/guardian) as parent or legal guardian of _______________________________ (youth’s name), in consideration of my child being allowed to participate in the _______________________________ (insert program name) Program, on behalf of my child, myself, my family, my heirs, representatives, assigns, executors or administrators, I hereby release and agree to hold UMass Boston, its trustees, directors, officers, employees, servants, representatives, agent licensees, successors and assigns, harmless from and against any and all claims, losses, damages, expenses (including attorneys’ fees, and all court and litigation costs) and liability (including statutory liability), resulting from injury and/or death of any person or damage to or loss of any property arising out of or in any way from the _______________________________ (insert program name) Program and my child’s participation therein.

Signature of Parent/Guardian  Printed Name  Date

RELEASE TO PARTICIPATE IN PROGRAM ACTIVITIES

I hereby give permission for my son/daughter to participate in all activities, including field trips in the youth programs including transportation to and from UMass Boston including program related activities from the date of his/her acceptance throughout his/her involvement with the program, and I hereby certify that the statements on this form are true to the best of my knowledge and belief. We further agree to support the administrative rules of the program and to cooperate with the staff to our fullest extent.

Signature of Parent/Guardian  Printed Name  Date

MEDIA RELEASE

Beginning as of the date of execution of this release, that photographs, whether still or action, videos, film and/or motion pictures (hereinafter “Pictures”) and/or audio recordings (“Recordings”) may be taken of my child, individually or with others, by or on behalf of UMass Boston in connection with this youth program, and agree that all rights therein shall irrevocably, exclusively, unconditionally and perpetually belong to UMass Boston and that such rights are freely assignable by UMass Boston. I further agree that, without any compensation or notification to or approval by me, the Pictures or Recordings, and website postings may be used, reproduced or otherwise disseminated or published by or on behalf of UMass Boston directly or indirectly for any purpose, including but not limited to advertising and/or promotional purposes, in any manner, and at any time that UMass Boston desires. For good and valuable consideration, receipt of which is hereby acknowledged, I hereby agree to release and discharge UMass Boston, its trustees, directors, officers, employees, servants, representatives, agents, licensees, successors and assigns from any and all claims, demands or causes of action that I may now have or may hereafter have for libel, defamation, invasion of privacy or right of publicity, infringement of copyright or violation of any other right arising out of or relating to any utilization of the Pictures or Recordings.

Signature of Parent/Guardian  Printed Name  Date
HEALTH HISTORY

(To be completed by Parent/Guardian)

Name of Youth (first & last): _____________________________________________________

Has the youth had, or does the youth have, any of the following? Circle “Y” for Yes and “N” for No. (If yes, please explain on separate sheet of paper)

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
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<tbody>
<tr>
<td>Heart disease/ heart defect</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Seizures/epilepsy/fainting spells</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Concussion or serious head injury</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Heat stroke/exhaustion</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Contact lenses/glasses</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Any limitations that restrict running, swimming, participating in group recreational activities?</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Will the youth need to take any medications during program hours?

Yes ______ No ______

If yes, provide instructions here:
____________________________________________________________________________________
____________________________________________________________________________________

Use this space to provide any additional information on the youth’s physical health about which the youth program at UMass Boston should be aware:
____________________________________________________________________________________
____________________________________________________________________________________

HEALTH INSURANCE INFORMATION

Please include a copy of your child’s health insurance card. If you cannot provide the requested health insurance card; please provide the following insurance information:

<table>
<thead>
<tr>
<th>Insurance Carrier</th>
<th>Policy Number</th>
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Cardholder’s Name
HEALTHCARE PROVIDER SIGNATURE

If you are unable to have a healthcare provider (physician, nurse practitioner, physician assistant) sign this form, you may submit a copy of a school physical form signed by a healthcare provider instead. The physical must have occurred within the last twenty four (24) months.

TO BE COMPLETED BY A HEALTHCARE PROVIDER

________________________________________________________________________

is physically able to participate in a general/sport program designed for youth with and without disabilities and his/her immunizations are up to date.

Comments/Limitations:

________________________________________________________________________

________________________________________________________________________

IMMUNIZATIONS

Please fill out the information below or provide a copy of your child’s immunization records.

Youth’s name: ________________________________________________________________

Date of birth: __________________________________________________________________

MEASLES, MUMPS AND RUBELLA (MMR) VACCINE
First dose must be after age 12 months; 2 doses required.
MMR #1 ____/____/____ MMR #2 ____/____/____

POLIO VACCINE
A minimum of three doses of either inactivated polio vaccine (IPV) or oral polio vaccine (OPV) are required. If a mix of (IPV/OPV) was used, four doses are required.

Completed primary series of polio immunizations? □ YES □ NO

Dates:

____/____/____

____/____/____

____/____/____

DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE
Minimum of four doses of DTaP/DTP/DT or at least three doses of Td is required. A booster dose of Td is required for all program participants who will be entering grades seven through 10. For participants who will be entering grades 11 and 12, a booster of Td is required if it has been more than 10 years since the last dose of DTaP/DTP/DT/Td. (Tdap is also acceptable.)

Completed primary series of DTaP/DTP/DT? □ YES □ NO
HEPATITIS B
Three doses of Hepatitis B vaccine are required if born on or after Jan. 1, 1992.
Dose # 1 ___/___/____ Dose #2 ___/___/____ Dose #3 /___/___

EXCEPTIONS
• RELIGIOUS OBJECTION: The individual must submit a written statement, signed by a parent/guardian if a minor, to the effect that the individual is in good health and stating the reason for such objections.
• MEDICAL: The individual must submit certification by a physician stating that the physical condition of the individual is such that his or her health would be endangered by such immunization.

CONSENT TO TREAT MINOR PATIENTS
Your child has been accepted to a youth program at the University of Massachusetts Boston. University Health Services offers first aid to minors who are participating in university sponsored youth programs. Massachusetts law requires consent of a parent/legal guardian for medical care of minors, including first aid. Please complete the following consent form to allow University Health Services to provide first aid to your child.

I, ______________________________________, am the parent/legal guardian of ______________________________________, currently a minor, whose date of birth is _____/_____/_________. I authorize the University of Massachusetts University Health Services to provide first aid to the youth.

I understand that, should my minor child need more extensive medical care I will be notified by a healthcare provider through University Health Services. I also understand that if the injury/illness is determined to be life threatening or require immediate medical attention beyond first aid, that an ambulance will be called to take my child to the hospital and that the provider will make every effort to contact me.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions that I have prior to signing could be answered by calling University Health Services at (617) 287-5660.

AUTHORIZATION TO ADMINISTER MEDICATION
Please provide separate sheets for each medication.

Signature of Parent/Guardian Printed Name Date
A.) TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that ____________________________________ (youth’s name) receive the medication as prescribed below by our licensed healthcare provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the R.N. or other licensed healthcare provider will administer the medication.

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<th>Signature of Parent/Guardian</th>
<th>Printed Name</th>
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B.) TO BE COMPLETED BY THE LICENSED PRESCRIBER:

I request that my patient, as listed below, receive the following medication:

Name of youth: ______________________________________ Date of Birth: _____ / _____ / ________

Diagnosis: ______________________________________________________________________________

Name of medication: ________________________________________________________________________

Prescribed dosage, frequency and route of administration:

_________________________________________________________________________________________

Time to be taken during program hours: _______________________________________________________

Duration of treatment: _____________________________________________________________________

Possible side effects and adverse reactions (if any):

_______________________________________________________________________________________

Other recommendations: ___________________________________________________________________

Name of licensed prescriber and title (please print): ___________________________________________

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Signature of licensed prescriber | Printed Name | Date |
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