University of Massachusetts Boston

Youth Program Application

2017
APPLICATION INSTRUCTIONS

Participant’s Name: _________________________________________________________________

Parent/Guardian Name (print): ________________________________________________________

Program Name: ____________________________  Date Submitted: _________________________

If you are applying to a youth program at the University of Massachusetts Boston, please complete and mail the completed application packet to the address below:

________________________________________ (Program Name)

University of Massachusetts Boston
100 Morrissey Boulevard
Boston, MA 02125

Failure to complete all forms in the application may result in your child not being accepted into the youth program.

☐ Policies and Guidelines – Pg. 3
☐ Personal, Family, and Emergency Contact Information – Pgs. 4-5
☐ Release Forms – Pg. 6
☐ Health History – Pg. 7
☐ Health Insurance Information – Pg. 5
☐ Healthcare Provider Signature – Pg. 8
☐ Immunizations – Pgs. 8-9
☐ Consent to Treat Minor Patient – Pg. 9
☐ Authorization to Administer Medication – Pg. 10

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 (participant 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.

Signature of Parent/Guardian  Date
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 participants are required to have a completed application 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. If these forms are not received at least 3 weeks prior to the program start date your child may not be allowed to start the program.

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 participants 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.

WEATHER ADJUSTMENTS 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 participants 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.

<table>
<thead>
<tr>
<th>Signature of Parent/Guardian</th>
<th>Date</th>
</tr>
</thead>
</table>
PERSONAL, FAMILY, AND EMERGENCY CONTACT INFORMATION

Name of Participant (first & last): _______________________________________________________
____________________________________________________________________________________
Street Address  Apt. #
_____________________________________________________________________________________
City  State  Zip Code
Participant’s Cell Phone # (if applicable): ________________________________________________
Participant’s Date of Birth: ________________________ Participant’s Gender: male______ female_____
Name of School: _____________________________ Participant’s Grade: ______________________
Language Spoken at Home: ___________________ Hair Color: ______________________________
Eye Color: __________________________________ Height: _________________________________
Weight: ______________________    Can the participant 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 above. 
Name (first & last): ______________________________________________________________________
_______________________________________________________________________________________
Street Address  Apt. #
_______________________________________________________________________________________
City  State  Zip Code
Home Phone #:    ___________________________  Work Phone #:___________________________
Cell Phone #: __________________________________________
Relationship to Participant: _______________________________________________________________
Emergency Contact #2
Name (first & last): ________________________________________________

_________________________  __________________________
Street Address                  Apt. #

_________________________  __________________________
City                        State                  Zip Code

Home Phone #:  ____________________________  Work Phone #:  ____________________________

Cell Phone #:  ____________________________

Relationship to Participant: _________________________________________________________

Signature of Parent/Guardian  Date

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:

Insurance Carrier                  Policy Number

_________________________  ____________________________
Cardholder’s Name


RELEASE FORMS

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

GENERAL RELEASE

I, __________________________________________ (print) as parent or legal guardian of
____________________________________ (participant’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,
expenditures (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      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      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      Date
HEALTH HISTORY

AS A YOUTH PARTICIPANT, PARENT OR GUARDIAN I UNDERSTAND THAT: The information requested on this form is intended to help inform staff of any pre-existing medical conditions. If your child has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. This information will be kept in strict confidence and will only be shared with your permission. UMass Boston requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment. You are accountable for providing an accurate medical history. Final determination about whether to participate is the responsibility of UMass Boston’s consulting health care provider. If you have any medical issue that is not requested below, but which you think is important, please include that information.

(To be completed by Parent/Guardian)

Name of Participant (first & last): _____________________________________________________

Has the participant had, or does the participant 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>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<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>Asthma</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Easy Bleeding</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Emotional/psychiatric/behavioral issues</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Sickle cell trait or disease</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Food allergies or special diet</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Medication allergies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If “Yes” to any above please provide details:
________________________________________________________________________________________
________________________________________________________________________________________
Will the youth need to take any medications during program hours? Yes_______ No_______
If yes, provide instructions here:
______________________________________________________________________________________
Is the participant pregnant? (females only) Yes_______ No_______
If so, estimated due date is:________________________________
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:
______________________________________________________________________________________
______________________________________________________________________________________

PLEASE READ: As a participant, parent or guardian I understand and acknowledge that my failure to disclose relevant information may result in dismissal from a UMass Boston-Summer Youth Program. By signing my name I represent and warrant that I have provided all materials and important information to UMass Boston pertaining to my child’s medical, mental and physical condition and that it is accurate and complete. I agree to notify the program nurse of any changes in my mental, physical or medical condition prior to my Child’s scheduled program.

Signature of Parent/Guardian __________________________ Date __________

University of Massachusetts Boston – Youth Program Application v. 2017
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.**

**MUST BE COMPLETED BY A HEALTHCARE PROVIDER ONLY**

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

Comments/Limitations:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

<table>
<thead>
<tr>
<th>Healthcare Provider Signature</th>
<th>Printed Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Phone:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax:</td>
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</tbody>
</table>
IMMUNIZATIONS

The following immunizations are required of all participants before attending our programs.

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

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

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.)

HEPATITIS B
Three doses of Hepatitis B vaccine are required if born on or after Jan. 1, 1992.

MENINGOCOCCAL
Only required for overnight residential programs

EXCEPTIONS
If claiming a religious or medical objection, please attach information.

Please have your child’s medical provider fill out the form on the next page or provide an official record on office letterhead from the provider’s office. An official school record is also acceptable.
**CERTIFICATE OF IMMUNIZATION**

Name: ____________________________

Date of Birth: / / Sex: □ female □ male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date/Vaccine Type</th>
<th>Vaccine</th>
<th>Date/Vaccine Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)</td>
<td>1</td>
<td>Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Varicella (Var)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
<td>1</td>
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<tr>
<td></td>
<td>7</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Polio (e.g., IPV, DTaP-HepB-IPV)</td>
<td>1</td>
<td>Pneumococcal Polysaccharide (PPV23)</td>
<td>1</td>
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<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Influenza</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Inactivated</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Live (Intranasal)</td>
<td>3</td>
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<tr>
<td>Pneumococcal Conjugate (PCV7)</td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
<td>2</td>
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<td>3</td>
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<td></td>
<td>4</td>
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<tr>
<td>Other: Meningococcal is recommended for overnight program</td>
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</tbody>
</table>

**Serologic Proof of Immunity**

<table>
<thead>
<tr>
<th>Test (if done)</th>
<th>Date of Test</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella*</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>/ /</td>
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</table>

* Must also check Chickenpox History box.

**Chickenpox History**

☐ Check the box if this person has a physician-certified reliable history of chickenpox. **Date of chickenpox: / /**

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

**I certify that this immunization information was transferred from the above-named individual’s medical records.**

**Medical Provider name (print):** ____________________________ **Date:** ____________________________

**Signature:** ____________________________

**Address:** ____________________________ **Phone:** ____________________________
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, ________________________________ (print name here), am the parent/legal guardian of ________________________________ (print name of participant), currently a minor, whose date of birth is ____/____/_______. I authorize the University of Massachusetts Boston Health Services to provide first aid to the youth.

I understand that, should my minor participant 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.

Signature of Parent/Guardian

Date

PERSONAL SAFETY POLICY

University Health Services reserves the right to limit or restrict a participant’s ability to carry any item, or wear clothing, deemed to pose a safety risk to the individual and/or others while participating in the program. This includes, but is not limited to, weapons (whether real or fake), explosives, sharp objects (including medical devices), inappropriate clothing or clothing with graphics deemed to be offensive. If the participant or his/her parent or guardian refuse to abide by this policy the participant may be restricted from participation until the issue is resolved to the satisfaction of the University Health Services RN or representative.

I agree to abide by the policy as stated above.

Signature of Parent/Guardian

Date
PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR OVER-THE-COUNTER MEDICATION

Over-the-Counter (OTC) Medication may at times need to be administered. All of the following medications will be administered as necessary unless you indicate below those meds you do not want your child to receive.

I hereby request that the following medications not be given to ______________________ (Participant’s Name). You may not dispense those checked except in an emergency.

___ Acetaminophen  ___ Ibuprofen    ___ Antacid
___ Benadryl/Antihistamine  ___ Triple Antibiotic Ointment   ___ Cough Drops
___ Calamine Lotion   ___ Hydrocortisone Ointment  ___ Sun Block

Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are checked.

The following Medication may be administered to summer youth participants following emergency medication specific protocol regardless of parental consent.

___ Albuterol Inhaler
___ Albuterol Sulfate Inhalation Solution
___ Benadryl
___ Epi-Pen Jr. or Epi-Pen

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 youth’s parents.

I understand that such administration will be done under the supervision of medical personnel.

I authorize the administration of over-the-counter medications to my child as indicated above.

Parent/Guardian Signature: ____________________________ Date: ________________
Home Phone #: ______________ Cell Phone #: __________ Work Phone #: ______________
AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

A.) TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that ____________________________________ (participant’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.

<table>
<thead>
<tr>
<th>Signature of Parent/Guardian</th>
<th>Date</th>
</tr>
</thead>
</table>

B.) TO BE COMPLETED BY THE LICENSED PRESCRIBER:

Please provide separate sheets for each medication.

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

Name of participant: ___________________________ 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):

<table>
<thead>
<tr>
<th>Name/Title</th>
<th>Office Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>Apt. #</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of licensed prescriber</th>
<th>Date</th>
</tr>
</thead>
</table>