**Texas A&M International University**
2010 Emergency Contact Information

**Personal Information:** (To be completed by Parent/Guardian)

First Name:______________________________Middle: _________________Last:____________________________

Date of Birth: ____________________________________Sex: Male ☐ Female ☐

Primary Contact:
Name: _______________________________________Relationship:_____________________________________

Contact Number: _______________________________

Secondary Contact:
Name:_________________________________________ Relationship:_____________________________________

Contact Number: _______________________________

**Insurance Information:** (All information will be destroyed/return at end of camp)

Is the participant covered by family medical/hospital insurance? Yes ☐ No ☐

**Photocopy of front & back of health insurance card(s) must be attached to form**

If YES, indicate carrier or plan name: _________________________________

Group #:__________________________________

Please indicate if you would like information Destroyed: ☐ Returned: ☐

**Allergies/Restrictions:** List all known (Describe restriction and/ reaction and management of the reaction)

Medication allergies (List): Reactions (List):

_______________________ ____________________________________________________________

Food allergies (List): Reactions (List):

_______________________ ____________________________________________________________

Other allergies (List: Include insect stings, asthma, etc.):

_______________________________________________________________________________________________

**Medications:** Please list all ALL medications (including over-the-counter or non-prescriptions drugs) taken routinely and “as needed”. Bring enough medication to last the entire time at camp. Keep it in original packaging/bottle the identifies the prescribing physician, the name of the medication, the dosage and the frequency

☐ **This person takes medication as follows:** OR ☐ **This person takes NO medications on a routine basis**

- Med #1: _________________Dosage: ____________Specific times taken each day:_______________________
  Reason for taking: ___________________________________________________________________________
- Med #2: _________________Dosage: ____________Specific times taken each day:_______________________
  Reason for taking: ___________________________________________________________________________
- Med #3: _________________Dosage: ____________Specific times taken each day:_______________________
  Reason for taking: ___________________________________________________________________________

**For additional medications attach additional pages**

**MUST BE SIGNED BY PARENT/GUARDIAN** **Child's Name:________________________**

- **Parent/Guardian Authorizations:** The health history provide is correct and complete to the best of my knowledge, and the person here in described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event T cannot be reached in an emergency, I hereby give permission selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.
- **Health Insurance Information:** I understand that:

**A.** The TAMIU camp staff will make every effort to insure that medical personnel are given to my child's health insurance information at the time of treatment when I have provided copier of necessary documents;

**B.** Not all medical treatment facilities will file insurance claims. If the situation occurs with my child, TAMIU will forward the bills to me and I agree to pay them within 60 days of receipt;

**C.** If TAMIU is required to obtain a prescription for my child, I agree to reimburse TAMIU for any co-payment or prescription expense incurred on my child's behalf;

**D.** TAMIU will notify the day my child is treated, provided that I have given correct contact information for myself and/or additional emergency contact. TAMIU will follow-up with written notification to me, along with copies of all documents related to my child's treatment;

**E.** If my child does not have health insurance, or I fail to provide TAMIU with necessary documentation for coverage, I agree to pay for all medical expenses, including prescriptions, incurred on behalf of my child.

Signature of Parent/Guardian:________________________________________________

Printed Name:________________________________ Date:____________________

## AUTHORIZATION FOR STOCK NON-PRESCRIPTION DRUG ADMINISTRATION BY CAMP HEALTH CARE PROVIDER

There may be times at camp when your child will ask for non-prescription medications/treatments to help relieve symptoms related to minor conditions such as poison ivy, headache, or upset stomach etc. A Registered Nurse (RN) or Licensed Practical Nurse (LPN) is always available at the Health Center to assist in the assessment of the camper's conditions and to respond appropriately in dispensing these medications/ treatments.

The **PARENT/GUARDIAN** must indicate which of the available non-prescription drugs/treatments **MAY NOT** be used or given by checking the appropriate boxes on the enclosed list.

### NON PRESCRIPTION TOPICAL/ ORAL MEDICATIONS:

- ☐ Alcohol Prep. Pads (wound cleaning)
- ☐ Aloe Vera Gel (moisturizing therapy)
- ☐ Ammonia Inhalants (fainting)
- ☐ Anti-fungal powder/spray or cream (Tenactin or similar)
- ☐ Anti-microbial wipes (wound cleaning)
- ☐ Anti-biotic ointment/ Bacitracin (wound cleaning)
- ☐ Medicated Powder (skin irritations)
- ☐ Calagel/Caladryl/Calamine Lotion (skin irritations)
- ☐ Foille Medicated First Aid Spray (sunburn/minor burn)
- ☐ Hydrocortisone Cream 1% (skin irritations)
- ☐ Hydrogen Peroxide 3% (wound cleaning)
- ☐ Ice Packs
- ☐ Mediosine Sting Ease Swabs

**MUST BE SIGNED by Parent/Guardian:**

- I give permission for Registered Nurse, trained in accordance with the State of Texas Health Department regulations and under authorizations of the Camp Physician through the 2010 TAMIU, to administer non-prescription medications, as indicated above in accordance with the label directions and with attentions to the relevant side effects also listed on the label above medications.

**Signature of Parent/Guardian:**

________________________________________________**Date:**____________________