



Shattuck-St. Mary's 2019 Summer Programs

Health and Liability Forms

Dear Parents,

We are looking forward to having your son or daughter on campus this summer. In the event that he or she needs medical attention, we want to be prepared. Therefore, we are asking that you please take the time to read the below information and to fill out the appropriate health forms as indicated and return them as soon as possible.

Requirements

The following requirements are mandatory for camp or program participation:

1. **All campers** must have the following forms completed and submitted before arriving on campus.

- 1. Waiver and Release of Claims**
- 2. SSM Summer Programs Health Form**
- 3. Medical Information and Consent Form**
- 4. Non-Prescription Medications**
- 5. PHOTOCOPY OF INSURANCE CARD (FRONT/BACK).**

2. **All campers** must have all immunizations up to date.

3. Campers must have a doctor complete a physical exam if: (1) they are subject to a chronic medical condition (e.g., asthma) that requires prescription medication, (2) within the last six (6) months they have had an exacerbation of symptoms or otherwise had an active bout of any of the following: asthma, diabetes, Mononucleosis, 2 head injuries; (3) within the last one (1) month they have worn a cast or had any other orthopedic injury, or (4) any other serious injury or illness. Please contact Mary Hart at Mary.Hart@s-sm.org if in need of a form for a physical.

4. Campers taking prescription medications must bring them in the **original pill bottle** OR a doctor's written note about orders/dosage of medication. Unmarked medications cannot be dispensed by the summer camp nurse.

If any requirement is not completed, the school reserves the right to refuse a camper's participation in any activity on campus, including residence in a dorm.

All paperwork can be returned to Mary Hart in our Summer Programs Office.

Post Office Box 218, Faribault, Minnesota 55021

Telephone 1-800-617-8469

Fax 507-333-1680

Medical Care

The Kramer House Health Center is located on campus and is equipped to handle routine health care needs. A camp nurse will hold office hours at the health center every day from 7AM to 10AM unless otherwise noted. During off hours, a nurse will be on call. There is also an athletic trainer available. In the event that urgent medical care is needed, a hospital with a full-service emergency room is within five minutes by car. Please indicate on health forms if prior authorization for care is needed for insurance.

In the event of injury or illness, Shattuck St. Mary's reserves the right to require the camper to return home. If more than one overnight monitoring by a nurse is deemed medically necessary, a fee of \$200.00 per night will be charged to the family.

Our medication policy consists of the nurse collecting all controlled prescription medications at check-in. Medications will be dispensed in the mornings in the dining hall and in the evenings in the dorms by a nurse. It is the camper's responsibility to see the nurse for their medications. Some over-the-counter medications are available from the nurse, dorm parent, or trainer upon request. Please complete the "Non-Prescription Medications" form to indicate what your child is allowed to have. Please avoid bringing over-the-counter medications (unless the medication is not in our inventory) as we have these available for your child.

Students who wear glasses should bring an extra pair if possible. One pair should be shatter-proof for athletic purposes. Students who wear contact lenses should also bring a pair of glasses.



Shattuck-St. Mary's 2019 Summer Programs Health and Liability Forms

1. Waiver and Release of Claims 2018

Please read the form below carefully and be aware that in registering yourself or your minor child for participation in a camp at Shattuck-St. Mary's ("SSM"), you will be waiving and releasing all claims for injuries or illnesses you or your child might sustain arising out of _____ (the "Activity").

I recognize and acknowledge that there are inherent risks of serious personal injury or illness or death involved in participation in the Activity, and in consideration of me or my child being permitted to take part in the Activity and otherwise to use the facilities and services of SSM, I agree to assume the full responsibility and risk for any injuries, illnesses, damages or loss, regardless of severity, which I or my child may sustain arising out of or related in any way to my or my child's participation in the Activity or presence on or use of SSM's facilities. I agree to waive and relinquish all claims I or my child may have against SSM and/or its officers, directors, employees or agents, arising out of or related to my or my child's participation in the Activity or presence on or use of SSM's facilities. I fully release and discharge SSM and its officers, directors, employees and agents from any and all claims for injuries, illnesses, damages or loss which I or my child may have or which may accrue to me or my child arising out of or related to the Activity. I further agree to indemnify and hold harmless and defend SSM and its officers, directors, employees and agents from any and all claims resulting from injuries, illnesses, damages and losses sustained by me or my child or otherwise arising out of, connected with, or in any way associated with the Activity. In the event of an emergency, I authorize SSM officials to secure from any licensed hospital, physician and/or medical personnel any treatment deemed necessary my child's immediate care and agree that I will be responsible for full payment of any and all medical services rendered.

I agree to pay for all damages to the facilities or property of SSM caused by me or my child's negligent, reckless or willful actions and agree to indemnify and hold harmless and defend SSM and its officers, directors, employees and agents from any and all claims by third parties caused by me or my child's negligent, reckless or willful actions.

I also give permission for my or my child's picture(s) and name to be published in SSM publications, videos, websites, brochures, etc. I give permission for me or my child to be quoted in school publications. I give permission for my or my child's name to be published on the school's websites. I give SSM permission to issue press releases to media sources concerning me or my child. I hereby grant permission to use any and all photographic imagery and video footage taken of me or my child, without payment or any other consideration. I understand that such materials may be published electronically or in print, or used in presentations or exhibitions.

I have read and fully understand the above waiver and release of all claims.

Student Signature (if over 18) _____

Date ___/___/___

Parent Signature (if student is under 18) _____

Date ___/___/___

Student Name (please print) _____



Shattuck-St. Mary's 2019 Summer Programs Health and Liability Forms

2. SSM Summer Programs Health Form

Boys' Hockey____ Girls' Hockey____ Figure Skating____ Synchro____ ESL____ Other (name)____
Student Name _____ M/F Birthdate ____/____/____ Grade _____

History Circle Yes (Y) or No (N)

Have you or do you have:

- | | | | |
|--|-------|---|----------------------|
| 1. Injury or illness since your last exam? | Y / N | 24. Have you had? (circle all that apply) | |
| 2. A chronic or ongoing illness? | Y / N | anemia | sprain |
| 3. Ever been hospitalized? Y / N reason _____ | | abnormal bleeding | diabetes |
| 4. Ever had surgery? | Y / N | abnormal bruising | diabetes |
| 5. Allergies to medications, bee stings, pollens,
or foods? | Y / N | broken bones | vision loss |
| Please list _____ | | stress fractures | scoliosis |
| Type of reaction: _____ | | seizures | heart murmur |
| 6. A heart murmur? | Y / N | viral myocarditis | depression |
| 7. High blood pressure? | Y / N | chicken pox | rheumatic fever |
| 8. Restricted from sports for heart problems? | Y / N | hearing loss | eating disorder |
| 9. Ever had a concussion? When _____ | Y / N | single organ | chemical dependence |
| 10. Ever had a head injury? When _____ | Y / N | mononucleosis | high blood pressure |
| 11. Knocked out or had memory loss? When _____ | Y / N | hepatitis | sickle cell disease |
| 12. Asthma? List medication _____ | Y / N | eye loss | undescended testicle |
| 13. Severe viral infection last month? | Y / N | ADD/ADHD | other psychological |
| | | Explain _____ | |

Female Athletes:

- | | | |
|---|-------|---|
| Do you have regular menstrual periods? | Y / N | 25. Do you use any special equipment? Y/N |
| When was your most recent menstrual period? _____ | | 26. Do you have any other concerns? |
| How many periods did you have in the last year? _____ | | _____ |
| | | _____ |

During or after exercise have or do you ever:

- | | |
|---|-------|
| 14. Fainted or felt dizzy? | Y / N |
| 15. Had chest pain? | Y / N |
| 16. Had racing heart or skipped heartbeats? | Y / N |
| 17. Do you tire more easily than your friends? | Y / N |
| 18. Become ill from exercising in the heat? | Y / N |
| 19. Wheeze, cough, or have trouble breathing? | Y / N |
| 20. Has any family member or relative died of a
heart problem before age 35? | Y / N |
| Before age 50? | Y / N |
| 21. Height _____ | |
| 22. Weight _____ | |
| 23. List medications currently taken daily: _____ | |

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I approve participation in athletic activities. I hereby authorize release to the school's athletic trainer, nurse, coach, and medical providers of the information contained in this document. Upon written request, I may receive a copy of this document for my personal health care provider.

Athletes must have written permission from the treating physician to participate if wearing a cast

Parent or legal guardian signature: _____ Date: ____/____/____



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3. Medical Information and Consent Form

We/I, the parents/legal guardians of _____, ____/____/____, M/F, Boarding/Day,
(Student name) (Date of birth) (Circle one)

authorize the Shattuck St.-Mary's Health Center staff, including, without limitation, the school medical director, nurses or athletic trainers, to administer to our child any health care deemed advisable by a medical doctor, registered nurse, dentist or other provider licensed by the State of Minnesota or any other qualified health care professional under the general supervision of a physician as long as our child is a camper at Shattuck-St. Mary's School.

In the event of an emergency, we consent to the immediate transfer of our child to any hospital or appropriate health care facility. We authorize a representative of the SSM Health Center to consent on our behalf to any emergency medical or dental treatment to be rendered to our child and to release pertinent information to the appropriate health care professionals. All reasonable attempts to contact us in advance of such emergency or other non-routine treatment will be made, provided medical circumstances permit. We also authorize the release of information by any off-campus provider to the SSM Health Center. We authorize the health care professionals at the Health Center to disseminate any pertinent medical information to the appropriate school personnel: trainers, coaches, teachers, dorm parent and/or any other school personnel deemed necessary.

This consent may be used for any off-campus health emergencies. In such cases, the SSM representative present shall be deemed a representative of the Health Center for the purpose of authorization and consent. We agree that we are exclusively responsible for the payment of all medical and dental services rendered to our child other than routine services provided directly by the SSM Health Center. Any copy of this consent shall have the same force as the original.

Parent/Guardian (print) _____ (signature) _____
Date _____

_____ Street
Address

_____ Town/City State Zip Code Country

Home Phone _____ Cell Phone (student) _____

Work Phones (mother) _____ (father) _____

Cell Phones (mother) _____ (father) _____

E-mail addresses (mother) _____ (father) _____

*Emergency Contact (primary) _____
name relationship name home/cell

Secondary _____
name relationship home/cell

*ALLERGIES _____

*CURRENT MEDICATIONS _____

*SIGNIFICANT MEDICAL HISTORY _____

LAST TETANUS ____/____/____

DOES YOUR STUDENT'S HEALTH INSURANCE REQUIRE PRE-AUTHORIZATION? Yes () No ()

*While it is the School's ethical responsibility to respect and maintain patient confidentiality, we must be able to share pertinent information on a "need to know" basis to promote the health and safety of an individual student with appropriate school personnel as outlined in the School Handbook.



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4. Non-Prescription Medications

The following is a list of non-prescription/over-the-counter medications that Shattuck-St. Mary's Health Center nurses are able to administer to the students as needed/directed per standing orders from our Medical Director.

Acetaminophen (Tylenol)	Debrox drops	Milk of Magnesia
Allegra	Delsym cough syrup	Mylanta
Bacitracin/Neosporin	Glyoxide drops (canker sores)	Pepto Bismol
Benadryl	Hydrocortisone 1% cream	Robutussin cough drops
Biofreeze (topical analgesic)	Hypotears	Robitussin DM
Blistex	Ibuprofen (Advil)	Sudafed
Calamine Lotion	Immodium	Sunscreen SPF15
Carmex	Kaopectate	Tinactin (antifungal)
Cepacol Lozenges	Metamucil	Tolnaftate (antifungal)
Chloraseptic Spray	Midol	Tums
Claritin		Zantac
		Zyrtec

PARENT/GUARDIAN AUTHORIZATION

1. I give permission for the school nurses, athletic trainers, and/or school personnel designated by the school nurses to administer medications listed above to my student, _____, when he/she is on campus or on an off campus trip **EXCEPT for the following:** _____

2. I release all school personnel from any and all liability in the event of any adverse reaction resulting from the use or administration of the medication(s) in relation to this request when the medications are given as ordered.

3. I will notify the SSM Health Center of any changes to the list of non-prescription medications excepted or allowed.

4. I give permission for the nurse to communicate with the appropriate school personnel and consulting physician regarding any information that needs to be disseminated or obtained concerning nonprescription medication.

Parent/Guardian Signature _____

Date ___/___/___