West Virginia Department of Health and Human Resources

Child Health Assessment

Child's Name _____ Parent/Guardian _____

DOB ___/___/_____ Home Phone _____ Address _____

Child Care Facility/School _____ _____

Child Care Facility/School Phone _____ Work Phone _____

Note: A copy of the HealthCheck exam report attached to a copy of the child's immunization record may be substituted for this form.

Health history and medical information pertinent to routine child care and emergencies:

Date of Exam ____/____/_____

Allergies to food or medicine:

Length/Height	Weight	Head Circumference	Blood Pressure
_____in/cm %ile _____	_____in/cm %ile _____	_____in/cm %ile _____	_____in/cm %ile _____

Physical Examination	Normal	Abnormal/Comments
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic/Tone		
Developmental (e.g. ddst)		

Immunizations	Birth to 1 Month	2 Month	4 Month	6 Month	12-18 Month	4-6 Years
DTP/DTaP						
Polio						
HIB						
HEP B						
MMR						
Varicella						
Other (PCV7)						

Note: Ages and number of boosters may vary when immunizations start at older ages.

Screening Tests (If completed)	Date	Normal	Abnormal/Comments
Lead			
Anemia (HGB/HCT)			
Urinalysis (UA)			
Tuberculosis (TB)			
Hearing			
Vision			

Date of Last Dentist's Exam

Note: Age-appropriate health services and immunizations must follow the schedule recommended by AAP.

Health Problems or Special Needs

Recommended Treatment/Medications/Special Care (attach additional sheets if necessary)

Medical Care Provider

Address

Phone

MD
DO PA
CRNP

_____

Date **Signature of Physician or CRNP**

West Virginia Department of Health and Human Resources

Emergency Information/Permission Form for Children in Child Care Settings

A. Family Information

1. Child's Name: _____ Birth Date: _____ Gender: ☐ Male ☐ Female

Home Address: _____

Child's School: _____ School Phone: _____

School Address: _____

Child's Doctor: _____ Doctor's Phone: _____

Doctor's Address: _____

Insurance Company: _____ Policy Number: _____

Preferred Hospital/Clinic for Emergency Care: _____

2. Parent/Guardian Name: _____ Phone: _____

Address: _____

Employer/School Name: _____ Work/School Phone: _____

Employer/School Address: _____

3. Parent/ Guardian Name: _____ Phone: _____

Address: _____

Employer/School Name: _____ Work/School Phone: _____

Employer/School Address: _____

B. Emergency Contact: Names and telephone numbers of individuals to contact in case parents cannot be reached in an emergency:

Name	Physical Address	Telephone Number

C. List of people with permission to pick child up from care (anyone <u>not</u> listed <u>cannot</u> pick up child without written permission from parent):

Name	Physical Address	Telephone Number

Special Instructions: Biological/custodial parents must be given access to their children unless there is a court order preventing contact. Individuals with court orders against them preventing child pick up:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Other restrictions on child pick-up: _____

D. List any allergies, illnesses, regular medications, special needs and concerns:

E. Permission to Receive Medical Care:

I, _____ give my permission for _____
(Name of Parent/Guardian) (Child Care Provider Name)

to consent for _____ to receive emergency medical, dental or surgical
(Name of Child)

treatment if I cannot be reached. I place the following restrictions on medical treatment : _____

F. Permission to Transport:

- ☐ I do not give the child care provider permission to transport my child for non-emergency reasons.
- ☐ I give the child care provider permission to transport my child for non-emergency reasons, such as to and from school or school activities, shopping, field trips, etc.
- ☐ In the event of an emergency, I prefer that the child care provider call an ambulance to transport my child.
- ☐ In the event of an emergency, I give permission for the child care provider to transport my child.

I place the following restrictions on transportation:

Parent/Guardian Printed Name: _____ Date: ___ / ___ / ___

Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Marshall Recreation Center and Campus Recreation
Assumption of Risk, Waiver, and Release from Liability

In consideration of the use of the property, facilities and/or services of the Marshall Recreation Center, owned by Provident Resource Group - Marshall Properties, LLC, and the Department of Campus Recreation, managed by CENTERS, LLC, including any travel related thereto, the undersigned agrees as follows:

1. **RISK FACTORS.** The undersigned understands and acknowledges that the use of equipment and facilities provided by the Department of Campus Recreation at Marshall University and participation in Campus Recreation programs (Intramural, Informal, Instructional, Group Fitness, Physical Sports, Weight and Cardiovascular Training, Climbing, Swimming and any other programs and services sponsored by Campus Recreation and/or activities occurring in the building) involves risk including, but not limited to the following: risk of property damage, bodily injury, including, but not limited to permanent disability, paralysis and possibly death. These risks may result from the use of the equipment or facilities, from the activity itself, from the acts of others or the or from the unavailability of emergency medical care.
2. **ASSUMPTION OF THE RISK.** The undersigned voluntarily assumes all risks described in Section 1 above that may arise out of or result from the use of the equipment or facilities, and/or the services of the Marshall Recreation Center. Exception being any injuries caused by the gross negligence or willful or wanton misconduct of any officials, officers, employees, agents, or volunteers of Marshall University, Provident Resource Group - Marshall Properties, LLC, and CENTERS, LLC.
3. **ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES.** The undersigned acknowledges reading and knowing all policies and procedures relating to the activities, facilities, and/or equipment and understands that the safe and proper use of facilities, equipment or participation in the activity is dependent upon carefully following such policies and procedures. The undersigned agrees to comply with and abide by all rules and regulations of the Marshall Recreation Center and of Marshall University. The Campus Recreation staff reserves the right to temporarily or permanently revoke or terminate the undersigned's membership privileges for any violations of the rules and regulations of the Marshall Recreation Center and of Marshall University or for any violations of the policies and procedures relating to the activities, facilities, and/or equipment of the Marshall Recreation Center.
4. **PREREQUISITE SKILLS AND TRAINING.** The undersigned acknowledges that he or she has the requisite skills, qualifications, physical ability and training necessary to properly and safely use the equipment, facilities, and to participate in programs and activities developed by Campus Recreation. The undersigned agrees that if he or she has any questions as to what skills, qualifications, or training is necessary to properly use the equipment, facility, or participate in such programs and activities, then he or she shall direct such questions to the appropriate Campus Recreation staff member on site.
5. **WAIVER.** The undersigned waives the protection afforded by any statute or law in any jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving the release does not know or suspect to exist at the time of executing the release. This means, in part, that the undersigned is releasing unknown future claims.
6. **INDEMNIFY AND DEFEND.** The undersigned hereby releases, waives, indemnifies and holds Marshall University, Department of Campus Recreation, CENTERS, LLC, Provident Resource Group - Marshall Properties, LLC, and all of their officers, trustees, directors, employees, and agents (hereinafter jointly referred to as "indemnitee") harmless from any and all claims, causes of action, suits, liability, losses, or damages for any property damage, property loss or theft, personal injury, death or other loss arising from or relating to the undersigned's use of the property, facilities, and/or services of the Marshall Recreation Center.
7. **PAY.** The undersigned agrees to pay for any and all damages to any property or indemnitee caused by the undersigned negligently, willfully or otherwise.
8. **REPRESENTATIVES.** The undersigned enters into this agreement for him/herself, his/her heirs, assigns and legal representatives.
9. **CONSENT FOR EMERGENCY TREATMENT.** The undersigned, as a participant in the subject activity, hereby consents to medical treatment in a medical emergency where the undersigned is unable to consent to such treatment.
10. **INSURANCE.** The undersigned understands the Campus Recreation does not carry participant insurance and that the undersigned will be solely responsible for any medical, health or personal injury costs relating to undersigned's use of the property, facilities and/or services of the Marshall Recreation Center. The undersigned is encouraged to have a medical physical examination and purchase health insurance prior to any and all participation.
11. **JURISDICTION.** This Assumption of Risk, Waiver, and Release from Liability Agreement shall be governed in all respects by the laws of the State of West Virginia. The parties agree to use the State of West Virginia for Jurisdiction and the County of Cabell as Venue for any disputes between the parties.
12. **SEVERABILITY.** If any term, clause, or provision of this Assumption of Risk, Waiver, and Release from Liability Agreement is held to be illegal, invalid or unenforceable, or the application thereof to any person or circumstance shall to any extent be illegal, invalid or unenforceable under present or future laws effective during the term hereof or of any provisions hereof which survive termination, then and in any such event, it is the express intention of the parties that the remainder of this Agreement, or the application of such term, clause or provision other than to those as to which it is held illegal, invalid or unenforceable, shall not be affected thereby, and each term, clause or provision of this Assumption of Risk, Waiver, and Release from Liability Agreement and the application thereof shall be legal, valid and enforceable to the fullest extent permitted by law.
13. **ACKNOWLEDGMENT.** The undersigned has read and fully understands this agreement and realizes it relates to surrendering and releasing valuable legal rights and does so freely and voluntarily.

PARTICIPANT NAME: _____

SIGNATURE: _____ DATE_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth:_____ Gender: _____

Emergency Contact Name: _____Emergency Contact Phone Number: _____

Consent and Release on Behalf of Minor

I am the parent or legal guardian of the above named minor. I have read and understand the agreement and realize it relates to surrendering valuable legal rights of the minor and myself. I agree to be bound by all the terms of the agreement. I also give my consent to the participation in the activity of the minor.

SIGNATURE: _____

(Signature of Parent/Legal Guardian Consent and Release on Behalf of the Minor)

YOUTH CAMP HEALTH HISTORY FORM

Marshall University
Campus Recreation

The information on this form is required for children to participate in our camp. The information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to the camp director upon the participant's arrival in camp. Provide complete information so that the camp can be aware of your needs. **Please Note:** You will not be able to drop off your child for camp unless this form is completed in its entirety.

Mail or email this form to the address below prior to the start of the session

Marshall Recreation Center
Attn: Zach Kula
402 Thundering Herd Drive
Huntington, WV 25755
reccamps@marshall.edu

Name_____ Birthdate _____ Age at Camp_____
Last First Middle MM/DD/YYYY

Home Address _____
Street Address City State Zip Code

Gender: Male ☐ Female ☐

Custodial Parent/Guardian_____Phone_____

Home Address _____
(If different from above) Street Address City State Zip Code

Business Address _____ Phone_____
Street Address City State Zip Code

Second Parent/Guardian or Emergency Contact_____

Address_____ Phone _____
Street Address City State Zip Code

Business Address _____ Phone_____
Street Address City State Zip Code

Third contact if neither parents cannot be contacted _____

Relationship_____Phone _____

Address _____
Street Address City State Zip Code

Fourth contact if third cannot be contacted _____

Relationship_____Phone _____

Address _____
Street Address City State Zip Code

-Continued on next page-

List of individuals with permission to pick child up from Camp.
Anyone not listed cannot pick up child without written permission from custodial parent/guardian received prior to pick up time.

Name _____

Relationship_____Phone _____

Address _____

Name _____

Relationship_____Phone _____

Address _____

Name_____

Relationship_____Phone _____

Address _____

Name _____

Relationship_____Phone _____

Address _____

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

If so, indicate the carrier or plan name_____ Group #_____

Carrier Address_____

Parent/Guardian Authorization: The health history is correct and complete as far as I know, for the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the Healthy Herd™ Youth Camp to provide health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the Healthy Herd™ Youth Camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I also understand that any and all expenses incurred by a medical emergency will be covered by myself and/or my insurance carrier, and will not be covered by the Healthy Herd™ Youth Camps nor Marshall University Campus Recreation.

Signature of parent/guardian or adult staff member _____

Printed Name_____Date _____

Name of Insured_____ Relationship to participant_____

Social Security Number of policyholder or insurance ID number _____

-Continued on next page-

Participant Name: _____

ALLERGIES (List all known) Describe reaction and management of the reaction.

Medication Allergies (list)

_____ _____

_____ _____

Food Allergies (list)

_____ _____

_____ _____

Other allergies (list)—include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

MEDICATIONS BEING TAKEN

Please list **ALL** medications (including over-the-counter or non-prescription drugs) that would need to be taken during a day of camp. Healthy Herd Youth Camp will not be able to administer or store medication for any camper. If a child will need to take medication throughout the day, please reach out to the Camp Coordinator (information above) for the specific policies and guidelines for administering medication. The Healthy Herd Youth Camp will have the ability to store and hold emergency medication (such as EpiPens). The camp staff will not directly administer any medication to campers, including emergency medication.

☐ This person **takes medication** as follows: **-OR-** ☐ This person **takes no medication(s)** 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 _____

Attach additional pages for more medications.

Identify any medications taken during the school year the participant does/may not take during the summer: _____

Name of Family Physician_____ Phone_____

Address_____

Name of Dentist/Orthodontist_____ Phone_____

Address_____

Hospital Preferred_____City _____

RESTRICTIONS (the following restrictions apply to this individual)

Does not eat ☐ Red meat ☐ Pork ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs

Other_____

Physical Activity Restrictions (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

-continued on next page-

FOR OFFICE USE ONLY

1. Updates or additions to health history noted: ☐ yes ☐ no ☐ none required

   a. Date of changes: _____

   b. Reasons for changes: _____

2. Medications received:

3. Current health needs identified:

4. Observational notes: