CONSENT TO SECURE MEDICAL TREATMENT

IMPORTANT - This information must be complete and submitted to URI for attendance to the camp.

Participant/Camper Name (please print): _____

Consent to Secure Medical Treatment Authorization: I herby give permission to have my child treated by the URI's authorized personnel, to provide appropriate health care, to their ability and level of training, administer prescribed medications (if authorized by a physician) and to perform and seek first-aid medical treatment. In the event that my child's behavior is felt to be unsafe or unmanageable, or if an illness or injury should arise in which a doctor's diagnosis is required, I authorize the Camp Director to dismiss my child early, in which case I will assume responsibility for arranging transportation for my child from the Camp at the time specified by the Camp management staff. In the event of an emergency requiring medical attention beyond first aid, I hereby grant permission to a physician or hospital personnel designed by URI authorized personnel to attend to my child in the event that I cannot be reached though my emergency contact phone number(s).

I agree to the release of any records necessary for insurance purposes. I give permission to URI's management staff to arrange necessary transportation for my child for emergency situations. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp management to secure and administer treatment and if necessary, 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 University of Rhode Island Board of Governors for Higher Education, their Agents, Employees and the State of Rhode Island.**

I acknowledge that the Emergency Contact Information, the Consent to Secure Medical Treatment Authorization and all Health History Forms for the Camper ***is correctly filled out to the best of my knowledge.***

Signature of Parent/Guardian: _____ Date: _____

Parent/Guardian Name (print): _____

Relationship to Minor Child: _____

PARENTS/LEGAL GUARDIAN - YOUR SIGNATURE INDICATES CONSENT TO PROVIDE HEALTH CARE, ADMINISTER PERSCRIBED MEDICATIONS AND SEEK EMERGENCY MEDICAL TREATMENT.