Maryland Department of State Police
1201 Reisterstown Road
Reisterstown, Maryland 21208

MEDICAL TREATMENT AUTHORIZATION

(To be completed by Parent/Guardian)

Does your child need an accommodation to participate in the 2021 Youth Leadership & Law Enforcement Seminar? Yes _____ No_____ If yes, please explain:

_____
_____
_____
_____

How would you describe your child's current physical condition?

Excellent_____ Good _____ Fair _____ Poor_____

Does your child have any physical restrictions for participation in the program? If yes, please explain:

_____
_____
_____
_____

Will your child be able to participate in the Function Fitness Assessment Testing (FFAT)?

Yes _____ No_____

Is your child currently taking medication; prescribed or non-prescription, supplements, herbals, nutritional? (Please list **all** medications currently being taken. Also include the medication taken, the reason, dosage and frequency on the attached Medication Form)

Yes _____ No_____ If yes, please advise:

_____
_____
_____
_____

Does your child have any allergies or reactions to insect bites, plants, foods (seafood, dairy products, nuts, etc.) or any other medical limitations?

Yes_____ No_____ If yes, please list, identify and explain each allergy or reaction:

_____
_____
_____
_____

Maryland Department of State Police
1201 Reisterstown Road
Reisterstown, Maryland 21208

MEDICAL TREATMENT AUTHORIZATION

Does your child have any special nutritional requirements? Yes _____ No_____ If yes, please explain:

_____
_____
_____

Has your child been prescribed an EPI Pen? Yes _____ No _____ If yes, please explain your child's condition for use and dosage:

_____
_____
_____

Is your child capable of self-administering the EPI Pen? Yes _____ No _____

Has your child been prescribed a rescue inhaler? Yes _____ No _____ If yes, please explain and frequency of use:

_____
_____
_____

Is your child capable of self-administering the rescue inhaler? Yes _____ No _____

I, the undersigned, consent to any emergency medical or dental examination, diagnosis or treatment and hospital care deemed to be necessary as recommended by a physician or medical professional at a licensed hospital, medical, or emergency care facility and I authorize the Maryland Department of State Police, the chaperone of my child, to obtain the above, should circumstances require it. I agree and understand that all reasonable efforts will be made to contact the parties listed on the form in the case of an emergency; however, if I or they cannot be reached, I give permission for the Maryland Department of State Police and/or its representatives to act on my behalf and to authorize necessary treatment and services to the child.

I, the undersigned agree to the same waivers, indemnification and releases of liability as stated in the **PARENT PERMISSION/WAIVER OF LIABILITY/PHOTO RELEASE FORM** and herein in regards to any and all injury, and or claims related to or deriving from any emergency medical or dental services while attending the 2021 Youth Leadership & Law Enforcement Seminar. I also agree to be liable and pay for any and all costs and expenses incurred in connection with such emergency medical or dental services rendered to the child.

Physician Name: _____Physician Telephone _____

Insurance Carrier_____ Insurance Card #_____

Maryland Department of State Police
1201 Reisterstown Road
Reisterstown, Maryland 21208

(Please provide a copy of <u>both</u> sides of your insurance card with the application)

MEDICAL TREATMENT AUTHORIZATION

ACKNOWLEDGEMENT/SIGNATURE: My signature below indicates that I have read all of the above and understand all the information contained herein. I am confirming that my child has permission to participate in the 2021 Youth Leadership & Law Enforcement Seminar and all related activities, unless otherwise specified on this document. I also authorize emergency medical treatment if it is necessary for my child. I hereby provide my signature freely and voluntarily.

Participant's Name: _____ Date of Birth: _____

Address: _____

City_____ State_____ Zip Code _____

Participant's Signature_____ Date_____

(Parent/Guardian Signature <u>Required</u> if participant is under 18 years old.)

Parent/Guardian's Signature_____ Date_____

Parent/Guardian's Printed Name_____

Relationship to Child_____

Home telephone_____ Cell Phone Number_____

Work Telephone_____

Parent/Guardian's Signature_____ Date_____

Parent/Guardian's Printed Name_____

Relationship to Child_____

Home telephone_____ Cell Phone Number_____

Emergency Contact_____

Maryland Department of State Police
1201 Reisterstown Road
Reisterstown, Maryland 21208

MEDICATION FORM

(This form must be completed and submitted by all participants)

Participant's Name: _____ Date of Birth: _____

List any and **ALL** medication(s) to be taken: Include the reason, dosage and frequency:

_____
_____
_____
_____
_____

List any and **ALL** allergies to medication(s):

_____
_____
_____
_____
_____

I give my child permission to take the following:

Acetaminophen - Tylenol or Generic ☐ Yes ☐ No

Antacid - TUMS, Maalox, Mylanta or Generic ☐ Yes ☐ No

Antihistamine - Benadryl or Generic ☐ Yes ☐ No

Aspirin ☐ Yes ☐ No

Decongestant - Sudafed or Generic ☐ Yes ☐ No

Ibuprofen - Advil or Generic ☐ Yes ☐ No

All medications both prescription and over-the-counter MUST be in the original bottles, prescription medication must be in your child's name

Participant's signature _____

(Parent/Guardian Signature Required if participant is under 18 years old.)

Parent/Guardian signature _____

Parent/Guardian signature _____