Maryland 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 2020 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? Yes ☐ No ☐
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? (List **all** medications currently being taken. Please include 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.)?

Yes ☐ No ☐ If yes, please list, identify and explain each allergy or reaction:

_____
_____
_____
_____

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Does your child have any special dietary 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 ☐ N/A ☐

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 ☐ N/A ☐

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 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 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 2020 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 #_____

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

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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 2020 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_____

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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:
(If not applicable, please indicate NONE below)

_____
_____
_____
_____
_____

List any and **ALL** allergies to medication(s):
(If not applicable, please indicate NONE below)

_____
_____
_____
_____
_____

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 _____