PRECOLLEGE SUMMER INSTITUTE
YOUTH MEDICAL RELEASE FORM - SAMPLE

This Medical Release Form is authorized for UCLA Summer Sessions activities for the dates specified below and for any extended period agreed upon by The Participant and the UCLA Office of Summer Sessions:

__________________________________       _________________________________________
Name of Program        Dates of Attendance

While my child is attending or traveling to or from this UCLA Summer Sessions function, I HEREBY AUTHORIZE THE ADULT UCLA STAFF/FACULTY MEMBER, OR IN HIS/HER ABSENCE OR DISABILITY, ANY ADULT ACCOMPANYING OR ASSISTING HIM/HER, TO CONSENT TO MEDICAL EXAMINATION AND TREATMENT OR MENTAL HEALTH SERVICES FOR THE SAID MINOR AND TO ARRANGE TRANSPORTATION FOR THE SAID MINOR TO RECEIVE SUCH SERVICES:

___________________________________________________________________________
Participant/Minor Name

____________________________________     ________________________________________
Participant’s Parent/Guardian Name                            Date

☐ I, the Participant’s Parent/Guardian, represent and warrant that the said minor is under my guardianship, conservatorship, or other legal authority and that I am legally competent to understand and complete this form.

☐ I understand that UCLA will make reasonable efforts to contact me, or the emergency contact named below before taking any action authorized hereunder. I give permission for UCLA Summer Sessions to contact my child’s medical or mental health provider for the purpose of confirming medical conditions/treatments or obtaining additional information in order to provide appropriate care. I hereby waive and release the Staff and Faculty from any liability for any injury or illness incurred while in classes/program. I also understand that there is risk of injury to the named program participant as a result of program activities, and knowingly and voluntarily assume all risk of such injury.

☐ I understand that I will be financially responsible for any medical attention needed during a program/class or resulting from an injury received. I certify that I and/or my medical insurance shall be the insurance coverage for any medical treatment.

☐ I hereby authorize any hospital which has provided treatment to the above-named minor pursuant to the provision of Family Code Section 6910 to surrender physical custody of such minor to the adult UCLA Staff/Faculty member/s, upon completion of treatment. This authorization shall remain effective until my child completes his/her activities in this program.

☐ I hereby certify that my child is in good health and can travel to and participate in all functions of the UCLA Summer Sessions as described above. I also understand that if my child is taking any medications, that he/she will be responsible for taking his/her own medicine without supervision.
I understand it is my responsibility to keep the information on this form updated (including Health History and parent/guardian status) by contacting the Office of UCLA Summer Sessions.

The information below has been pre-filled based on the information you provided during this registration process and will only be used in the event that your child needs emergency medical treatment.

Emergency Contact First Name                                        Emergency Contact Last Name
______________________________________________________________________

Date                                                                                       Relation to Participant
______________________________________________________________________

Emergency Home Telephone          Emergency Work Telephone              Emergency Mobile Telephone
______________________________________________________________________

Medical History
History of operations or serious illness:
______________________________________________________________________

Mental Health History
Diagnoses, hospitalizations and dates:
______________________________________________________________________

Is The Participant currently taking any medications?

Adverse Reactions and Allergies
DO NOT give my child the following medications under any circumstances:
______________________________________________________________________
______________________________________________________________________

Allergies to medications, food, insect bites, environmental factors, etc.:
______________________________________________________________________
______________________________________________________________________

Medical Insurance and Medical/Mental Health Provider: