Medical Authorization

Ross Mathematics Program · ross@rossprogram.org · (773) 809–5659

INSTRUCTIONS: Type the information where indicated here, then print this document and write in the medical information requested. Then scan that paper copy as a PDF file, and email it to medical@rossprogram.org.

During the 2023 Ross Program, I, _____ (parent/guardian name), the parent/guardian of _____ (student name) (the "Participant"), can be reached at _____ (phone number).

My medical insurance is provided by _____ (insurance company) and they can be reached by phone at _____ (insurance phone number).

The policy holder's name is _____ (policy holder), born on _____ (birthday).

My medical insurance policy number is _____ (policy number).

My group number is _____ (group number) with name _____ (group name).

I understand that every reasonable effort will be made to contact me at the contact information I have provided in the event of an emergency. In the event that I cannot be located immediately, the authorities of the Ross Mathematics Foundation may take such temporary measures as they deem necessary. I give permission to Central Ohio Primary Care or other physicians selected by the Ross Mathematics Foundation to treat, hospitalize, order injection, anesthesia, or surgery for the Participant. I give permission for the release of this health information form as well as any accompanying information or medical records to medical professionals in the event of injury or illness.

To the best of my knowledge and belief, the Participant is and has been in normal good health and is free from all communicable or contagious diseases. Should the Participant manifest any condition where there appears to be reasonable grounds for suspecting the presence of a communicable or contagious disease, I agree that a physical examination may be performed. Also, I agree that if any such disease is found, the Participant will comply with the regular quarantine or isolation procedures of the camp and of the community. I agree that the Participant will submit to surveillance testing for COVID–19 which may include mandatory antigen or PCR tests.

Signed _____ (Parent or legal guardian) on this _____ (Date)

Describe below any medical conditions or concerns, dietary/seasonal/medical allergies, non-allergy dietary restrictions, and disability accommodations of which we should be aware:

I understand that certain prescription medications are considered to be "controlled substances" and require dispensation by a medical professional. I also understand that I may authorize my child to self-administer certain other medications, and/or I may authorize the Ross Mathematics Program counselors to administer certain other medications.

_____ will be bringing the following prescription medications:
student name

And the following non-prescription medications:

I authorize my child to ...
self-administer the prescription medications listed: Yes ☐ No ☐
self-administer the non-prescription medications listed: Yes ☐ No ☐

I authorize the Ross Math Program counselors...
to administer the prescription medications listed: Yes ☐ No ☐
to administer the non-prescription medications listed: Yes ☐ No ☐

In the event that my child experiences a headache, fever, nausea, sunburn, muscle pain, or other minor ailment and has not brought with them an appropriate medication to treat such ailment, I authorize the Ross Mathematics Program counselors to administer the following non-prescription medications to my child:

Acetaminophen (Tylenol): Yes ☐ No ☐
Aspirin: Yes ☐ No ☐
Ibuprofen (Advil): Yes ☐ No ☐
Naproxen (Aleve): Yes ☐ No ☐
Calcium Carbonate (Tums): Yes ☐ No ☐
Bismuth Subsalicylate (Pepto-Bismol): Yes ☐ No ☐
Calamine Lotion: Yes ☐ No ☐
Sunscreen: Yes ☐ No ☐

Signed _____ on this _____
Parent or legal guardian Date