UMass Boston
Youth Program Participant Medical Forms
2025

Name of Participant:
Parent/Guardian:
Address:
Phone:
Name of Medical Provider
Address:
Phone:

Participant's Name | Date of Birth

Youth Program Medical Requirements

All documentation must include your child's name and birthdate

1. **Application**

   All forms must be signed by parents/guardian.

   1. Consent to Treat Minor Patients, signed by parents/guardian (page 4)
   2. Health History (page 5)
   3. Authorization, Waiver and Consent for OTC Medication (page 7)

2. **Immunization records**

   Submit one of the following:

   1. Certificate of Immunization (page 6) OR
   2. Immunization Form from medical provider or school record (this is usually given to you at a yearly physical to give to the school nurse)

3. **Required Vaccines**

   The following vaccines are required. If you need a Religious or Medical Exemption for any required vaccine(s), please submit a letter from the medical provider.

   1. **Td** (Td, Tdap, Dtap)
   2. **MMR:** Two (2) doses
   3. **Varicella:** Two (2) doses
      *If child had the Chickenpox (varicella), they may not have received a full Varicella series (may have 1 or none). If that is the case, you can submit documentation from your child's medical provider stating they had chickenpox.
   4. **Hep B**: Three (3)doses
   5. **Polio:** Three (3) or Four **(**4) doses, depending on type given
   6. **Meningococcal (MCV4)** REQUIRED ONLY FOR OVERNIGHT PROGRAMS

4. **Physical exam**

   1. Must include wording to the effect of "student is cleared for full participation in school and sports without restriction" ****signed by medical provider**. **(**Medical Provider refers to the child's Pediatrician, aka "PCP" which may be a Doctor (MD, DO), Nurse Practitioner (NP), or a Physician Assistant (PA)).**
   2. **Must be dated within the last 18 months**

THESE SECTIONS ARE ONLY REQUIRED IF APPLICABLE TO THE PARTICIPANT

5. **Medications** If your child will be taking **any** medications while at their program, Prescription or Over the Counter (OTC), you must submit orders from **medical provider**. The medications must be sent to the program in their original packaging with your child's name on them.
    1. **If child needs medication that the nurse will store and administer** submit**:** *"Authorization for Administration of Medication"* form (page 9)
    2. **If child needs medication *and can take it by themselves*:**
    submit: "*Authorization to Self-Administer Medication*" form (Page 10)

6. **Anaphylactic Allergy**
    If your child has an anaphylactic allergy:
    1. Submit an Anaphylactic Action Plan from your child's **medical provider** which should include if the student can self-carry and self-administer their epi pen.
    2. Send child to program daily with Epinephrine Auto Injectors (aka EpiPens) which should always be kept in pairs of two (2) and in the original packaging from the pharmacy with the prescription attached.

7. **Asthma**:
    If your child has asthma:
    1. Submit an "Asthma Action Plan," from your child's **medical provider** which should specify if the student may self-carry and self-administer the medications.

8. **Diabetes**:
    If your child has diabetes:
    1. Submit a "Diabetes Care Plan" from their **medical provider**. UHS staff will have a meeting (can be a phone call) with parent/guardian before the start of the program to review care plan and create an individualized program care plan for the student.
    2. Plan to send your child every day to their program with all of their necessary diabetes supplies as we do not have these supplies to give them.

9. **Other chronic medical conditions**
    If your child has any other medical problems:
    1. Submit action plan, medication orders as appropriate and plan to coordination with our nursing staff to create individual care plan for your child while they are at our program.

Participant's Name _____ | Date of Birth _____

CONSENT TO TREAT MINOR PATIENTS

Your child has been accepted to a youth program at the University of Massachusetts Boston. University Health Services offers first aid to minors who are participating in university sponsored youth programs. Massachusetts law requires consent of a parent/legal guardian for medical care of minors, including first aid. Please complete the following consent form to allow University Health Services to provide first aid to your child.

I, _____(*print name here*), am the parent/legal guardian of _____(*print name of participant*), currently a minor, whose date of birth is ____/____/____. I authorize the University of Massachusetts Boston Health Services to provide first aid to the youth.

I understand that, should my minor participant need more extensive medical care I will be notified by a healthcare provider through University Health Services. I also understand that if the injury/illness is determined to be life threatening or require immediate medical attention beyond first aid, that an ambulance will be called to take my child to the hospital and that the provider will make every effort to contact me.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions that I have prior to signing could be answered by calling University Health Services at (617) 287-5660.

_____

Print Name of Parent/Guardian

_____

Signature of Parent/Guardian **Date**

_____

Best contact phone #1 **Best contact phone #2**

_____

Alternate Contact **Relationship** **Phone number**

Participant's Name | Date of Birth

HEALTH HISTORY

AS A YOUTH PARTICIPANT, PARENT OR GUARDIAN I UNDERSTAND THAT: If your child has a pre-existing medical condition, **participation in any strenuous activities or recreational time may not be recommended. *This information will be kept in strict confidence and will only be shared with your permission.*** UMass Boston requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment. You are accountable for providing an accurate medical history. ***Final determination about whether to participate is the responsibility of UMass Boston's consulting health care provider***. If you have any medical issue that is not requested below, but which you think is important, please include that information.

(To be completed by Parent/Guardian)

Has the participant had, or does the participant have, any of the following? Check Yes or No.

	YES	NO		YES	NO
Medication allergies:			Asthma		
Food allergies or special diet			Easy Bleeding		
Seizures/epilepsy/fainting spells			Emotional/psychiatric/behavioral issues		
Diabetes			Sickle cell trait or disease		
Concussion or serious head injury			High blood pressure		
Heat stroke/exhaustion			Heart disease/ heart defect		
Contact lenses/glasses			Any limitations that restrict running, swimming, participating in group recreational activities?		

If "Yes" to any above, or there is any additional information on the youth's physical health please provide details here or add additional papers/documents:

_____

_____

Will the youth need to take any medications during program hours? (circle one) YES NO

If yes, please submit the form "**Authorization to Administer Medications" (page 8) as well as "Authorization to Self-Administer Medication" (page 9) if applicable.**

Is the participant pregnant? (females only) If YES, estimated due date_____

PLEASE READ: As a participant, parent or guardian I understand and acknowledge that my failure to disclose relevant information may result in dismissal from a UMass Boston Youth Program. By signing my name, I represent and warrant that I have provided all materials and important information to UMass Boston pertaining to my child's medical, mental and physical condition and that it is accurate and complete. I agree to notify the program nurse of any changes in my mental, physical, or medical condition prior to my Child's scheduled program.

_____

Signature of Parent/Guardian **Date**

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** □**female**

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated(Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**COVID 19(optional)** 2 doses -Moderna/Pfizer OR **one** dose of the J&J vaccine and at least one booster	1	
	3			2	
	4			3	

SerologicProof of Immunity		**Check One**	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox. **Date of chickenpox:** / /

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Name and Title of Licensed Provider (print): _____ ***Date:*** _____

Signature of Licensed Provider: _____

Address: _____ **Phone:** _____

Participant's Name | Date of Birth

PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR OVER-THE-COUNTER MEDICATION

Over-the-Counter (OTC) Medication may at times need to be administered. All of the following medications will be administered as necessary unless you indicate below those meds you do ***not*** want your child to receive.

I hereby request that the following medications **NOT** be given to (Participant's Name)_____

You may not dispense those checked except in an emergency.

	Acetaminophen (Tylenol)		Ibuprofen (advil/motrin)		Antacid
	Benadryl/Antihistamine		Triple Antibiotic Ointment		Cough Drops
	Calamine Lotion		Hydrocortisone Ointment		Sun Block

I understand that such administration will be done under the supervision of medical personnel. I authorize the administration of over-the-counter medications to my child as indicated above.

_____

Signature of Parent/Guardian **Date**

Please note that the following medications may be administered to summer youth participants following emergency medication specific protocol regardless of parental consent. In addition, 911 will be called as medically appropriate which may mean they will be transported to a local emergency room.

Albuterol Inhaler
Albuterol Sulfate Inhalation Solution
Benadryl
Epi-Pen Jr. or Epi-Pen

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the youth's parents.

Participant's Name | Date of Birth

ONLY REQUIRED IF APPLICABLE TO PARTICIPANT

AUTHORIZATION TO ADMINISTER MEDICATION

for all Prescription and Over the Counter Medications taken on a regular basis

Please provide separate sheets for each medication.

A.) TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child_____receive the medication as prescribed below by our licensed healthcare provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the Registered Nurse or other designated healthcare supervisor will administer the medication.

Signature of Parent/Guardian	**Date**

B.) TO BE COMPLETED BY THE LICENSED HEALTHCARE PROVIDER:

Please provide separate sheets for each medication.

I request that my patient, as listed below, receive the following medication:

Name of participant: _____Date of Birth: _____/_____/_____

Diagnosis: _____

Name of medication: _____

Prescribed dosage, frequency, and route of administration:_____

Time to be taken during program hours: _____Duration of treatment:_____

Possible side effects and adverse reactions (if any):_____

Other recommendations: _____

Name of licensed prescriber and title (please print):		
Name/Title	**Office Phone**	
Street Address		**Apt. #**
City	**State**	**Zip Code**
Signature of licensed prescriber		**Date**

ONLY REQUIRED IF APPLICABLE TO PARTICIPANT

Participant's Name | Date of Birth

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

For all prescription and over-the-counter medications that will be taken independently by participant

Please provide separate sheets for each medication.

Participant Name:_____

Address:_____

Date of Birth: _____

Program Name & Location:_____

This form must be completed fully in order for the student identified above to self-administer prescription medication during the program identified above (including inhalers, insulin, EpiPens)

A separate Authorization for Self-Administration of Prescription Medication must be completed for each medication to be self-administered.

Self-administration of medication requires the written authorizations (below) of a licensed health care professional and Participant's parent or legal guardian.

AUTHORIZATION FROM PRESCRIBER FOR SELF-ADMINISTRATION OF MEDICATION

Medication name:_____
Dosages:_____
Condition(s) for which medication is being administered:_____
Specific directions (e.g., on empty stomach, with water):_____
Time/frequency of administration: _____
If PRN, frequency:_____
If PRN, for what symptom(s): _____
Relevant side effect(s): _____
Dates medication shall be administered from _____
Special storage requirements: _____
Is Participant capable of self-administering this medication:_____

I hereby affirm that Participant has been instructed in the proper self-administration of the above-described medication.

Name of licensed prescriber and title (please print):

_____

Name/Title **Office Phone**

_____

Street Address **Apt. #**

_____

City **State** **Zip Code**

_____

Signature of licensed prescriber **Date**

_____

Signature of Parent/Guardian **Date**