

CONFIDENTIAL: STUDENT HEALTH & MEDICAL PERMISSION FORM
(Please print.)

Student's Full Name _____

OSAI Discipline _____ Date of Birth _____

Height _____ Weight _____ Hair Color _____ Eye Color _____

Street Address _____ City _____ Zip _____

Please answer each question below. Medical information is kept completely confidential and this form will be shredded after OSAI. **If your child has a serious medical condition requiring special care or medication, please include a letter of instruction from their physician.** This information is helpful should medical treatment be necessary during OSAI.

Is your child taking any medication? Yes No

If yes, please complete the attached Medication Administration Log. Additional logs will be available at student check-in on June 8 if more space is needed.

If prescription, list prescribing physician and their address: _____

All prescription medications must be brought in the original, properly labeled container from your pharmacist and will be administered by the OSAI nursing staff. Additionally, for the safety of all students, all over-the-counter medications brought to OSAI must be turned in to the nursing staff to administer as needed. Please give all medications (prescription and OTC) to the nurses at check-in. The infirmary also keeps a supply of common over-the-counter medications.

Does your child have a physical or psychological condition that the administrative and nursing staff should be aware of? Yes No

If yes, please explain: _____

Has your child been hospitalized or seen by a medical doctor or chiropractor within the last 12 months? Yes No

If yes, list date and reason: _____

It is recommended that students at Quartz Mountain have up-to-date vaccinations. Please indicate your child's current immunization status below:

My child is fully vaccinated.

My child is NOT fully vaccinated.

Is your child allergic to any medication or drugs? Yes No

If yes, please explain: _____

Does your child have any other allergies? Yes No

If yes, what? _____

Please return this form to the OAI office by Monday, May 13.
111 NW 9th Street, Oklahoma City, OK 73102

Name of primary physician: _____

Physician telephone (with area code): _____ City: _____

Is your child covered by medical insurance? Yes No

Name & address of insurance company: _____

Name of insured: _____

Policy number: _____ Group number: _____

Medical Permission

In case of medical emergency, I hereby release OAI and its employees, agents and representatives from any liability arising from obtaining or providing medical treatment, including transportation to seek medical treatment, except in cases of gross negligence or willful misconduct.

Student Signature Date

Parent/Legal Guardian Signature Date

Emergency contact daytime phone number (with area code): _____

Emergency contact nighttime phone number (with area code): _____

Permission to administer over-the-counter medications

The infirmary has a supply of common over-the-counter medications. Additionally, for the safety of all students, OTC medications brought to OSAI by the student must be turned in to the nursing staff to administer as needed.

I hereby authorize OSAI nursing staff to administer over-the-counter medications to my child for minor discomfort or illness on an "as needed" basis. Yes No

Parent/Legal Guardian Signature Date

Please return this form to the OAI office by Monday, May 13.
111 NW 9th Street, Oklahoma City, OK 73102

OKLAHOMA ARTS INSTITUTE Authorization to Disclose Health Information

Student Name _____
Last First Middle

OSAI Discipline _____ Date of Birth _____

I, _____ (“STUDENT”), hereby authorize OKLAHOMA ARTS INSTITUTE (“OAI”) to disclose specific health information from STUDENT’s Health Care Questionnaire as needed to ensure the health and safety of STUDENT, including but not limited to disclosure of such information to a hospital emergency room, physician and/or ambulance emergency medical technicians

I further understand that this Authorization to Disclose Health Information shall be effective during STUDENT attendance at the OAI Program, unless otherwise revoked in writing. Prior to June 1, 2019, **SUCH REVOCATION MUST BE DELIVERED TO OAI OFFICES DURING NORMAL BUSINESS HOURS at 111 NW 9th Street, Oklahoma City, OK 73102.** From June 1, 2019 to June 23, 2019, **SUCH REVOCATION MUST BE DELIVERED TO THE OSAI OFFICE AT QUARTZ MOUNTAIN LODGE AT 22469 LODGE ROAD, LONE WOLF, OK, 73655.**

THIS AUTHORIZATION SHALL EXPIRE AND WILL BE DEEMED REVOKED AT THE CONCLUSION OF MY ATTENDANCE AT THE OKLAHOMA SUMMER ARTS INSTITUTE. I further understand that any action taken on this authorization prior to its revocation date is legal and binding.

I further understand that I may request a copy of this signed authorization.

Student Signature Date

Parent/Legal Guardian Signature Date

Please return this form to the OAI office by Monday, May 13.
111 NW 9th Street, Oklahoma City, OK 73102

Medication Administration Log OSAI 2019

STUDENT NAME: _____

DISCIPLINE: _____

If your child requires medication during OSAI, please list below the medications, dosage, and frequency (according to the pharmacy label).

Med #1: _____	Med #2: _____	Med #3: _____
Dosage: _____	Dosage: _____	Dosage: _____
Frequency: _____	Frequency: _____	Frequency: _____

The OSAI nursing staff will use the following log to indicate time medication is administered each day.

NURSING STAFF USE ONLY:			
Sat 6/8			
Sun 6/9			
Mon 6/10			
Tue 6/11			
Wed 6/12			
Thu 6/13			
Fri 6/14			
Sat 6/15			
Sun 6/16			
Mon 6/17			
Tue 6/18			
Wed 6/19			
Thu 6/20			
Fri 6/21			
Sat-Sun 6/22-6/23			

Additional Medication Administration Logs will be available at check-in if additional space is needed.