

2024 BHSU DAKOTA DREAMS SUMMER CAMP (July 14-18, 2024)

PARENT/GUARDIAN SELF-ADMINISTRATION OF MEDICATION, RELEASE & WAIVER FORM

By my signature below, as parent(s) or guardian(s) of the Student Participant (“Participant”), and on behalf of the Participant and the Participant’s heirs, next of kin, successors in interest, assigns, personal representatives, and agents, and as consideration for Participant’s ability to engage in the following Activity entitled, _BHSU Dakota Dreams Summer Camp_, hosted by _BHSU_, and held at _BHSU, WDT, SD Mines, & Black Hills Region_, on the property of Black Hills State University, I do hereby:

1. Authorize _____ to possess and self-administer the following
(printed name of Participant)
prescription medication while on BHSU property or at the Activity;

I, _____, confirm by signing below that _____ (printed physician’s name) (student’s name) has asthma or anaphylaxis, or both, and is capable of self-administering the medication I prescribed below:	
_____ Name of Medication	_____ Purpose for Medication
_____ Form of Medication (e.g., tablet, liquid, inhaler, nebulizer, injection)	_____ Prescribed Dosage
Instructions (schedule, storage, and emergency instructions): _____ _____ _____ _____	
Period Prescribed: _____ to _____	
_____ Physician/Licensed Health Care Provider’s Signature	_____ Date

2. Warrant the accuracy and completeness of the following information from Participant’s physician (any preexisting physician statement may be attached to this Release to meet this requirement, so long as it remains accurate):

3. **Waive, release, and forever discharge any claim, cost, loss, damages, liability, or expense, including attorney’s fees, by Participant or I against the State of South Dakota, South Dakota Board of Regents, BHSU, and their officers, employees, agents, and volunteers (hereinafter, “Releasees”), and indemnify and hold harmless Releasees from any cause of action arising from the Participant’s possession or self-administration of prescription medication while on BHSU property or at the Activity, unless the liability is the result of Releasees’ sole negligence or willful misconduct.**

I have read this Self-Administration of Medication, Release & Waiver Form agreement. I fully understand its terms and understand that I and my minor child have given up substantial rights by signing it and have signed it freely and voluntarily without any inducement, assurance or guarantee being made to me and intend my signature to be a complete and unconditional release of all liability and of substantial rights. Additionally, I, the undersigned parent and/or legal guardian, hereby assert that I have full authority to bind.

Parent/Guardian

Signature: _____ Date: _____

Printed Name: _____

2024 BHSU DAKOTA DREAMS SUMMER CAMP (July 14-18, 2024)
PARENT/GUARDIAN CONSENT FOR OVER-THE-COUNTER MEDICATION FORM

By my signature below, as parent(s) or guardian(s) of _____ (“the Participant”), and on behalf of the Participant and the Participant’s heirs, next of kin, successors in interest, assigns, personal representatives, and agents, and as consideration for Participant’s ability to engage in the following Activity entitled, _BHSU Dakota Dreams Summer Camp_, hosted by _BHSU_, and held at _BHSU, WDT, SD Mines, & Black Hills Region_, on the property of BHSU, I do hereby:

1. Authorize Program Staff of the Activity to administer the following non-prescription (over-the-counter) medications (initial all that apply):

_____ All of the below medications	_____ No over-the-counter medications	
_____ Allergy/antihistamine medication	_____ Cold medication	_____ Cough syrup
_____ Ibuprofen	_____ Acetaminophen	_____ Antacid
_____ Kaopectate/generic concentrate	_____ Milk of Magnesia	_____ Sore throat lozenge
_____ Hydrocortisone cream	_____ Benadryl cream	_____ Antibiotic cream
_____ Tincture of Benzoin (helps tape adhere)	_____ Burn gels	_____ Sunscreen
_____ Eye drops for dryness/redness	_____ Antifungal cream	

Any of the following over-the-counter medications: _____

2. Declare the following to be the complete and accurate list of medications to which Participant is allergic, as well as the type of reaction Participant may suffer for each: _____

3. Further declare the following to be over-the-counter medication that Participant takes on a regular basis: _____

4. Acknowledge and agree that any authorized over-the-counter medications will be given only at the manufacturer’s recommended dosage and only where the medication is available to the program staff of the Activity. I further understand and agree that program staff reserve the right to use generic equivalents of the above medications if available.

5. **Waive, release, and forever discharge any claim, cost, loss, damages, liability, or expense, including attorney’s fees, by Participant or I against the State of South Dakota, South Dakota Board of Regents, BHSU, and their officers, employees, agents, and volunteers (hereinafter, “Releasees”), and indemnify and hold harmless Releasees from any cause of action arising from the Participant being administered the above indicated over-the-counter medications, unless the liability is the result of Releasees’ sole negligence or willful misconduct.**

Additionally, by my signature below, I aver reading this Consent for Over-the-Counter Medication Form in full, completely understanding its terms and that I am accurately providing all information solicited above. I, the undersigned parent and/or legal guardian, with full authority to bind, am freely signing this agreement.

Parent/Guardian

Signature: _____ Date: _____

Printed Name: _____