KU Pharmacy Summer Camp
Required Forms Packet

This combined document contains three separate forms that all require signatures from an adult (18 or over):

1. **Watkins Health Packet (pages 2 – 9)**
    a. Signatures and information required on:
        i. Page 5
        ii. Page 6
        iii. Page 7

2. **KU Pharmacy Summer Camp - Liability Release Form**
    a. Signature and information required on page 10

3. **KU Pharmacy Summer Camp – Media Release Form**
    a. Signature and information required on page 11

Please complete this document and return (by U.S. MAIL ONLY) by May 28, 2024.

IMPORTANT NOTE: Campers will not be allowed to start camp until all required forms within this document are completed and received by KU Pharmacy Summer Camp.

IMPORTANT NOTE: These forms cannot be returned via email because they collect confidential information.

KU WATKINS HEALTH SERVICES
The University of Kansas

DIRECTORS OF YOUTH PROGRAMS / CAMPS

Watkins Health Services (WHS) wants to be your program's health care provider. WHS can provide youth program participants the same high quality health care that KU students receive. These services include: Medical evaluations, allergy injections, pharmacy, laboratory and X-rays. All of our healthcare providers are board certified and many of our staff members are also parents. We understand the needs of campers and the concerns of parents, so if a camper comes to WHS for care, we will contact the parent or guardian as soon as possible (in compliance with Kansas laws).

While we prefer appointments to be scheduled, we certainly understand that issues arise which require prompt attention. Therefore, we have a Walk-In/Triage process to provide an immediate evaluation of the individual's needs. While we are not an Emergency Room, we do stabilize and transfer patients when that is needed.

Attached is a packet of forms designed so you can provide pages 2 – 8 as-is to each participant's parent/guardian. A packet should be completed for each program participant. Please have the family return the packet to you so that IF a participant is brought to WHS for care, it can accompany them to ensure we have the best possible information on health history as well as emergency contact information. The enclosed "Notice of Privacy Practices" is for information purposes only. There is nothing to complete on this document and it need not be returned.

If the participant is never seen at WHS for care during your program, please return the packet of information to the parents. It is very important that your office NOT retain this medical information once your program has ended. Returning the forms provides assurance to the parent/guardian that private health information is not being retained by your program and it removes responsibility you would have for secure storage or destruction of these records.

There are charges for office visits as well as for any services ordered such as lab tests, X-rays, medications, etc. If any charges are to be billed to an insurance company, **a copy of the participant's insurance card(s) must also be provided during the initial visit.**

PLEASE NOTE: We do not bill Medicare, Medicaid, KanCare, etc. as we are not a participating provider with these or similar government programs. Those charges would become the parent's/guardian's responsibility as noted on the enclosed Treatment Agreement.

Youth participants often bring personal medications or medical devices to campus, which are sometimes forgotten and left behind when they return home. Many of these are quite expensive, **so please be sure they are sent home with the participants**, or mailed to them if medications or devices are found after the participants leave. Our Pharmacy (by state law) **cannot** accept for disposal or for mailing **any** prescription medications or over-the-counter medications.

For our Hours of Operation and other information, please visit our website: www.studenthealth.ku.edu

If we can be of further assistance or answer any questions, please feel free to contact our Business Office at 785.864.9520.

Douglas Dechairo, M.D.
Director and Chief of Staff
Watkins Health Services

THE UNIVERSITY OF KANSAS
Watkins Health Services

Parent / Guardian Packet

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Health Services Information and Required Forms for Youth Program Participant

Accredited by **Accreditation Association for Ambulatory Health Care, Inc.**

Watkins Memorial Health Center ● 1200 Schwegler Drive ● Lawrence, KS 66045-7559
(785) 864-9500 ● www.studenthealth.ku.edu

THE UNIVERSITY OF KANSAS
Watkins Health Services

PARENTS / GUARDIANS OF YOUTH PROGRAM PARTICIPANTS

Watkins Health Services (WHS) is the student medical clinic on the Lawrence Campus of the University of Kansas. Occasionally, participants in youth programs/camps (i.e. "campers) are brought to WHS for medical needs and we assure you that WHS provides these campers with the same high quality care that KU students receive. All of our healthcare providers are board certified and many of our staff members are also parents. We understand the needs of campers and the concerns of parents, so if a camper comes to WHS for care, we will contact the parent or guardian as soon as possible (in compliance with Kansas laws)!

While we are not an Emergency Room, we do stabilize and transfer patients if that is needed. Most of the time, we only address the immediate issue and refer the patient back to their family physician for follow-up care.

We request that you complete this packet of forms and submit it to the Youth Program Director. In the unlikely event that your camper requires medical care during the program/camp, the forms will be brought to WHS to provide our staff important information about the camper's health conditions as well as emergency contact information in order to facilitate care.

Please understand, there are charges for office visits as well as for any services ordered such as lab tests, X-rays, medications, etc. If any charges are to be billed to an insurance company, a copy of the participant's insurance card(s) must also be provided during the initial visit.

PLEASE NOTE: We do not bill Medicare, Medicaid, KanCare, etc. as WHS is not a participating provider with these or similar government programs. Those charges would become the parent's/guardian's responsibility as noted on the enclosed Treatment Agreement.

If your camper is bringing any personal medication or medical device to campus, please be sure that:
1) The camper fully understands how and when to take the medication or use the device;
2) The device or any remaining doses of the medication return home with the camper at the end of the program.

For more information about the services and healthcare providers at WHS, please visit our website: www.studenthealth.ku.edu

If we can be of further assistance or answer any questions about this packet, please feel free to contact our Business Office at 785.864.9520.

YOUTH PROGRAM PARTICIPANT'S HEALTH HISTORY FORM

This completed form must accompany the individual on first visit to Watkins Health Services (WHS).
It is essential that our Treatment Agreement is signed by a parent or guardian.

Name of Program / Camp: KU School of Pharmacy - Summer Camp

Name & Contact Information for Program's Director: Joe Heidrick, Camp Director, pharmacy-camp@ku.edu

Youth's Name_____ Birth Date _____Sex_____
First Last Middle

Parent/Guardian Name _____Best Phone # to call _____

Address _____
Street City, State Zip

Emergency Contact, if other than above: Name _____ Best Phone # to call_____

Relationship to Youth _____

Name of Family Physician _____ Phone # _____

1. **Does the youth have any significant illness or disability?** ☐ NO ☐ YES If yes, please explain _____

_____

2. **Please check if the youth has or has had any of the following health conditions:**
   ☐ Asthma ☐ Mental health ☐ Dizziness/fainting ☐ Diabetes ☐ Epilepsy/seizures ☐ Kidney problems
   ☐ Gastrointestinal problems ☐ Cardiac ☐ Headaches ☐ Other _____

3. **Has the youth had any other significant illnesses, injuries, or surgeries?** ☐ NO ☐ YES If yes, please explain_____

_____

4. **Medications and their dosages taken by the youth**

Name of Medication	Dosage	Frequency	Reason Taken

5. **Immunization History – Please provide DATES for the following OR provide a copy of an Official Immunization Record**

   Last Tetanus (Tdap) booster: _____ (should be updated no longer than every 10 years)

   DTaP 1st _____ 2nd _____ 3rd_____ 4th _____ 5th _____

   MMR 1st _____ 2nd _____

   Polio 1st _____ 2nd _____

   Meningococcal conjugate vaccine (MCV) _____

   Hepatitis A 1st _____2nd _____

   Hepatitis B 1st _____2nd _____ 3rd _____

   Chicken Pox (Varicella) 1st _____ 2nd _____

   TB skin test – Date of Negative Result _____ OR Positive Result_____

6. **Is the youth allergic to any medications?** ☐ NO ☐ YES If Yes, please list _____
7. **Does the youth have any other allergies?** ☐ NO ☐ YES If Yes, please list _____
8. **Do any allergies require an EPI Pen to accompany camper?** ☐ NO ☐ YES If Yes, please list _____

If necessary, please attach additional health information.

KU WATKINS HEALTH SERVICES
The University of Kansas

Watkins Health Center
1200 Schwegler Drive • Lawrence, Kansas 66045
(785) 864-9500 • www.studenthealth.ku.edu
Nurse Helpline available 24/7 – (785) 864-9583

TREATMENT AGREEMENT

CONSENT TO TREATMENT

1. I consent to such health care as deemed necessary by the Watkins Health Services (WHS) providers including examinations, x-rays, lab tests, medication, and other diagnostic or therapeutic treatments. I understand no promises or guarantees have been made to me regarding the services received at WHS.
2. I understand it is my right to discuss any proposed treatment or service with my provider and that I may refuse such treatment or service.
3. I understand in some circumstances additional lab tests (reflex tests – usually done without needing a return visit or additional specimen) may be necessary due to an initial lab result; and I am consenting to such tests as part of the standard of care. My provider will explain when these tests may be needed.
4. I understand WHS is a teaching health facility and that students and residents acting under the supervision of licensed clinical staff may observe or be involved in my care. I understand I may decline such involvement by the student or resident.
5. I understand persons involved in WHS operations who are in the area during my patient care experience (e.g. WHS administrative staff or surveyors, building maintenance staff, or medical equipment technicians) may receive incidental knowledge of my care. I understand these individuals are bound by the same confidentiality regulations as the WHS providers.

GENERAL CONDITIONS FOR TREATMENT

6. I understand I should fully participate in my care by asking any questions about my condition or treatment and that I should provide complete and accurate information to the best of my ability about my health, including all medications and over-the-counter products and dietary supplements and any allergies and sensitivities. I understand that I should follow the treatment plan prescribed by my provider.
7. I understand WHS is not responsible for loss or damage to clothing, jewelry or other valuables in my possession.
8. I acknowledge the use of any video or audio capturing device during my appointment (camera, cell phone, etc.) must be discussed with the provider who will make the final decision on such use on a case-by-case basis.
9. I understand if I have tests or services performed at WHS which are ordered by an outside provider, the reports on those services will be sent to that provider and will also be included in my WHS medical record. It is my responsibility to follow-up with the outside provider concerning those results.
10. I will be respectful of all other patients and the staff in the health center.
11. I understand this Treatment Agreement will remain in effect as long as I receive treatment and services at WHS.

INSURANCE ASSIGNMENT

12. I hereby assign all benefits payable under the terms of my insurance policy/healthcare coverage to WHS, and I authorize payment directly to WHS for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I understand that if my healthcare coverage changes, I am to notify WHS Business Office.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

13. **I understand if KU waives my full required campus fees OR prorates the fees (student enrolls in less than 6 hours in fall/spring or less than 5 in summer) and I seek care at WHS during that semester I will be charged the remainder of the required Health Fee to enable me to receive full services.**
14. I understand WHS does not contract with all insurance companies and it is my responsibility to know if my insurance plan provides coverage for WHS services or requires a referral or pre-approval for such services.
15. I understand WHS is not a contracting provider for and cannot bill Medicare or Medicaid. If I have these government healthcare benefits, I am responsible for paying all WHS charges, and then seeking reimbursement from these programs.
16. I understand I am financially responsible to WHS for any charges and deductibles not covered by my health insurance and if I do not pay my bill within 90 days of my date of service, my overdue account will be sent to the University's Student Account Services office for collection resulting in an enrollment HOLD being placed on my University account.
17. I understand if I do not want my health insurance billed or a statement sent for my charges, I must immediately advise the WHS Business Office. Such charges become my responsibility.
18. I understand if I make an appointment and then fail to keep the appointment without notifying WHS at least 2 hours prior to my scheduled time, I will be assessed a "No Show" charge.

_____ Date of birth: _____ KU ID#_____ Date:_____
Print Patient Name (mm/dd/yyyy)

_____ _____
Signature (Patient, or Personal Representative) Printed Name and Description of Personal Representative' Authority to act

CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

In our Notice of Privacy Practices (NPP) we provide you information about how Watkins Health Services can use or disclose your youth program participant's medical information. As described in our NPP, we request your consent for any use or disclosure of medical information to carry out treatment, payment, or health care operations. You have a right to review our NPP before signing this Consent. It is available online:
https://studenthealth.ku.edu/sites/studenthealth.ku.edu/files/docs/Notice_of_Privacy_Practice.pdf

Or you may call and request that one be sent to you: 785.864.9507

By signing this Consent form, you:
(1) Acknowledge that a copy of the NPP has been provided or offered to you; and
(2) Consent to our use and disclosure of your participant's health information for treatment, payment, or health care operations, as described in the NPP.

You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed any health information in reliance upon this Consent.

_____ _____
Print Name of Youth Program Participant Date

_____ _____
Signature (Parent, Guardian or Representative) Relationship to Participant

_____ _____
Print Name of Parent, Guardian or Representative Phone number for Parent, Guardian or Representative

KU WATKINS HEALTH SERVICES
The University of Kansas

Watkins Health Center
1200 Schwegler Drive • Lawrence, Kansas 66045
(785) 864-9500 • www.studenthealth.ku.edu
Nurse Helpline available 24/7 – (785) 864-9583

NOTICE OF PRIVACY PRACTICES

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

Your Rights

You have certain rights regarding your health information which are explained in the following section.

- **Get a copy of your medical record:** You can ask to see or get a copy of your medical record and other health information Watkins has. Check to find out if we have electronic or paper versions available. We will provide a copy or a summary of your health information within 10 days of your request. We may charge a reasonable, cost-based fee.
- **Ask to amend your medical record:** You can ask us to amend your health information which you think is incorrect or incomplete. We may say "no" to your request, but you'll be told the reason in writing within two weeks.
- **Ask for confidential communications:** You can ask us to contact you in a specific way (e.g., home or cell phone), or to send mail to a different address. We will accept all reasonable requests.
- **Ask to limit what we use or share:** You can ask that certain health information for treatment, payment, or our operations not be used or shared. We may decline your request if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will accept your request unless a law requires the information be shared.
- **Get a list of those with whom we've shared your information:** You can ask for one free accounting each year of the times we've shared your health information for six years prior to your request date including the recipient and reason for sharing. All disclosures will be included except those about treatment, payment, and health care operations, and certain other disclosures (such as for public health purposes). There will be a charge for more than one accounting within 12 months.
- **Get a copy of this notice:** You can promptly receive a paper copy of this notice at any time, even if you have reviewed the notice electronically.
- **Choose someone to act for you:** If you have given someone a power of attorney (POA) or if you have a legal guardian, that person can act for you and make choices about your health care. If the POA includes access to your health information, you have the right to withhold disclosure of information to the other person. Ask a WHS Registration staff member to exercise this right.
- **File a complaint if you feel your rights are violated:** Without retaliation, you can complain if you feel we have violated your rights by contacting the Privacy Officer for this Clinic, or the KU HIPAA Privacy Official at 785-864-9525. You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting: **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, let us know. Tell us what you want us to do, and we will work to follow your instructions. Your information is never shared for marketing purposes or sold to another entity without your permission.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care, and share information in a disaster relief situation. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

Consent for Uses and Disclosures

I understand and consent for WHS to use or share my health information in the following ways:

- **Treatment:** Shared with other professionals treating you. ***Example:*** Watkins and the KU Counseling and Psychological Services Department may exchange your information as necessary solely to provide you treatment in either unit.
- **Department Operation:** Used to run our practice, improve your care, and contact you when necessary. ***Example:*** We use health information about you to improve our services or for health education training.
- **Payment for services:** Used to bill and get payment from health insurance plans or other entities. ***Example: I***nformation to your health insurance plan so it will pay for your services.
- **Other:** Shared in the following ways after meeting any required legal conditions:

1) Help with public health and safety issues**:** Situations such as: a) Preventing disease by outbreak reporting, b) Helping with product recalls, c) Reporting adverse reactions to medications, d) Reporting suspected abuse, neglect, or domestic violence, e) Preventing or reducing a serious threat to anyone's health or safety; 2) Research: Health research purposes ONLY when you have authorized it and when that research is approved under a strict new process and is compliant with federal regulations for human research; 3) Comply with the law: If local, state, or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law; 4) Address workers' compensation, law enforcement, and other government requests: a) For workers' compensation claims, b) For law enforcement purposes or with a law enforcement official, c) With health oversight agencies for activities authorized by law, d) For special government functions such as military, national security, and presidential protective services; 5) Respond to lawsuits and legal actions in response to a court or administrative order, or in response to a subpoena. For more information: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

- **I have the right to revoke consent** to use and disclose my health information as described in this document in writing at any time, except where we have already used or disclosed such information based on this consent.

Our Responsibilities

A record containing medical information about you is generated each time you receive services at Watkins. This section explains a bit more of our responsibilities:

- We are required by law to maintain the privacy and security of your protected health information
- We must inform you if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and provide you a copy of it. You are always welcome to download the current electronic version from our website
- We will not use or share your information other than as described here unless you approve in writing. If you do so, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Watkins Health Services
Revised 09-28-18

KU Pharmacy Summer Camp - Liability Release Form (2024)

I/We understand that the University of Kansas, the University of Kansas School of Pharmacy, the University of Kansas School of Pharmacy Summer Camp Program, the Kansas Board of Regents, the State of Kansas and their agents, officers and employees are not responsible for any injuries or illnesses of my (our) child (insert name) _____existing prior to or occurring during participation in the 2024 University of Kansas School of Pharmacy Summer Camp Program.

I/We authorize the employees and/or agents of the University of Kansas School of Pharmacy Summer Camp Program to act in accordance with their best judgment in any situation requiring medical attention, whether an emergency or not until such time as I (we) am (are) contacted to make decisions concerning treatment. I understand that no prescription medication, other than legally prescribed prescription medication brought to camp for conditions currently under treatment, will be administered to my (our) child unless emergency conditions require otherwise.

I (We), on behalf of myself (ourselves) and my (our) child, in consideration of the opportunity for my (our) child to participate in the program, hereby, waive, release, discharge the University of Kansas, the University of Kansas School of Pharmacy, the University of Kansas School of Pharmacy Summer Camp Program, the Kansas Board of Regents, and the State of Kansas and their agents, officers and employees from any claim of injuries or property damage which may be sustained by my (our) child during attendance at and participation in the University of Kansas School of Pharmacy Summer Camp Program. I (We) further agree to indemnify the University of Kansas, the University of Kansas School of Pharmacy, the University of Kansas School of Pharmacy Summer Camp Program, the Kansas Board of Regents, and the State of Kansas and their agents, officers and employees, and to hold the foregoing harmless from any and all claims of injury or property damage which are caused by or are the result of actions or omissions of my (our) child.

If the participant is 17-years-old or younger, a signature from a parent or guardian is required.

Signature of Parent or Guardian: _____

Date: _____

Health Insurance Information for the Pharmacy Student Camp Participant

Name of child covered: _____

Health Insurance Program/Company: _____

Policy No. or Plan Designation: _____

Name of Primary Individual on the Health Insurance Identification

Card:_____

Please attach a copy of the Health Insurance Identification Card.

IMPORTANT: Return this form with evidence of insurance coverage for the camp participant no later than Tuesday, May 28, 2024. Documentation may be a copy of an insurance identification/benefits card that reflects health insurance coverage for the camp participant.

GH:grh
05.16

University of Kansas School of Pharmacy, 2010 Becker Drive, Suite 2050, Lawrence, Kansas 66047
Ph.: 785-864-3591 Fax: 785-864-5265 email: pharmacy@ku.edu URL :pharmacy.ku.edu

KU Pharmacy Summer Camp – Media Release Form

Agreement to confer rights to use photographs or videos to the University of Kansas

I hereby give my consent for my image to be recorded during KU School of Pharmacy Summer Camp to be used by the University of Kansas in any way related to the publicity programs of this organization.

Date:_____

Name (please print): _____

Email: _____

Grade level: _____

Hometown: _____

Signature: _____

☐ By checking this box, I understand that the KU School of Pharmacy will continue to stay in touch with me via email and that I may opt out of those emails at any time.

If the participant is 17-years-old or younger, a signature from a parent or guardian is required.

Name of parent or legal guardian (please print) : _____

Signature of parent or guardian: _____

KU School of Pharmacy | 2010 Becker Drive, Lawrence, KS 66045
pharmacy@ku.edu | 785-864-3591

KU SCHOOL OF PHARMACY
The University of Kansas