

GLEN HELEN OUTDOOR EDUCATION CENTER SCHOOLCAMP HEALTH FORM

School _____ Grade _____

PERSONAL INFORMATION

Child's Name _____ Birthdate _____ Age _____ Sex _____

Street Address _____

City _____ State _____ Zip _____

Parent/Guardian 1 _____ Does this Guardian Reside at the Address Listed Above? **Y / N**

Phone (H) _____ Phone (C) _____ Phone (W) _____

Parent/Guardian 2 _____ Does this Guardian Reside at the Address Listed Above? **Y / N**

Phone (H) _____ Phone (C) _____ Phone (W) _____

Emergency Contact Other Than Parent/Guardian _____

Relationship to Child _____ Phone (H) _____ Phone (W) _____

HEALTH HISTORY

Child's Physician _____ Phone _____ Date of Last Visit _____

Are Immunizations up to date? _____ Date of Last Tetanus _____ Date Immunized for Hepatitis B _____

Please Check All Past and Present Health Concerns

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> Heart Disease/Defect | <input type="checkbox"/> Muscular Disorder | <input type="checkbox"/> Ulcers |

Please explain the above health concerns. _____

Please list allergies (food, drug, other) and reactions. _____

Please explain any recent infectious disease. _____

Does your child have any dietary restrictions or special needs? _____

Is there any reason why your child should follow a limited schedule of physical activity? _____

Are there any other behavioral or medical concerns we should be aware of? _____

MEDICAL INSURANCE

Name of Medical Insurance Company _____ Phone Number _____

Address _____

Name of Policy Holder _____

Policy Number _____ Group Number _____

All students are required to have coverage by accident and illness insurance during their stay. This insurance can be provided through the policy that Glen Helen has with the Special Markets Insurance Consultants, Inc.

Will this child be insured by the Accident/Illness policy offered through Glen Helen? **Y / N**

If yes, please make arrangements for coverage and payment with the coordinating teacher at your child's school.

MEDICATIONS

IMPORTANT: The Outdoor Education Center's first aid cabinet is stocked with first aid supplies, over-the-counter medications, and treatments for minor afflictions. Are there any over-the-counter medications or treatments that your child may **NOT** have due to allergy or parental/guardian preference? _____

Please list all prescription and non-prescription medications being brought to Glen Helen.

- **A physician's signature is required if prescription medications are to be administered at Glen Helen.** We recommend that your child is examined by his or her physician before arrival at Glen Helen.
- For both prescription and non-prescription medications, a physician's explanation and signature are required if the dosage or schedule to be followed is different from the prescription or manufacturer's dosage or schedule
- For prescription medications, the medications must be in their original containers and the child's name, dosage and schedule listed on the original container must be correct.
- For non-prescription medications, the medications must be in their original containers and the dosage and schedule on the container will be followed.

<u>Name of Medication</u>	<u>Dosage and Schedule</u>	<u>Purpose of Medication</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician's Signature _____ **Date** _____ **Phone** _____
(Required only if there are prescription medications or dosage variations on prescription or non-prescription medications.)

PARENT/GUARDIAN AUTHORIZATION (signature required for attendance)

The information contained in this form is correct, to the best of my knowledge, and the child described herein has permission to engage in all Glen Helen Outdoor Education Center activities, except as noted. I hereby consent to the following:

- authorization for consent for treatment may be given by any teacher or administrator of my child's school or school district or by the Outdoor Education Director or Assistant Director, any of whom may sign all documents necessary to obtain such treatment;
- the administration of any and all necessary medical treatment by a licensed physician or dentist either at his/her office or at a hospital;
- and the transfer of the minor, if necessary, to a specialty hospital, such as children's hospital.

I understand that the parent/guardian is fully responsible for the child's transportation if he/she is dismissed for disciplinary, behavior, or medical reasons. I absolve Glen Helen Outdoor Education Center and all of its employees of any and all liability, financial and/or otherwise arising from participation in the Outdoor Education Center program and/or the administration of medication to the child named herein under the terms of this release. I understand that Glen Helen Outdoor Education Center is not responsible for payment for any medical expenses incurred during participation in the program.

Signature of Parent or Legal Guardian _____ **Date** _____