

Counselor Name \_\_\_\_\_ School Counseling For \_\_\_\_\_

**Mount Hermon Outdoor Science School**  
**Health Emergency Information Form: Counselors UNDER 18**

Counselor Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Home Phone (     ) \_\_\_\_\_

Student Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Father's Work Phone (     ) \_\_\_\_\_ Father's Cell Phone (     ) \_\_\_\_\_

Mother's Work Phone (     ) \_\_\_\_\_ Mother's Cell Phone (     ) \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relation \_\_\_\_\_ Email \_\_\_\_\_

Day Phone (     ) \_\_\_\_\_ Eve. Phone (     ) \_\_\_\_\_ Cell Phone (     ) \_\_\_\_\_

**PARENT/GUARDIAN AGREEMENT**

**Please initial, fill in blanks where applicable and sign at the bottom.**

Initial ▼

\_\_\_\_\_ I give permission for my child \_\_\_\_\_ to attend Mount Hermon Outdoor Science School and all activities involving the program with full knowledge that I accept full responsibility for any injury or accident that may occur.

\_\_\_\_\_ I do agree to hold harmless the Mount Hermon Association and their employees, for any and all claims for injuries, causes for action, or liability related to Outdoor Science.

\_\_\_\_\_ I am aware that, at the discretion of the Science School Director, I will need to pick up my child due to medical or disciplinary reasons.

\_\_\_\_\_ I agree to be responsible for picking up my child. M.H.O.S.S. policy is that in the event that a child needs to be sent home for any reason, no amount of the paid fees will be refunded if my child has attended the Outdoor Science School program for 24 hours or more.

**Medication Agreement**

Note: By law, all Prescriptions and Over The Counter medications must be kept in the original container and will be kept by the Nurse in our 24 Hour 1<sup>st</sup> Aid facility, NOT in the child's cabin. Please give any and all medications to the teacher in its Rx or OTC container in a Ziploc bag labeled with the child's name and school—DO NOT put any medication in the child's luggage, as the child will miss part of the orientation when they have to retrieve it. A certified teacher will be available at all times during the week to dose any PRN (as needed) medication. Each day the Outdoor Science School Nurse will dose the Breakfast, Lunch, Dinner and Hour of Sleep medications for students with regular medications. Please contact your child's teacher for further information regarding our 24 Hour 1<sup>st</sup> Aid facility.

Are you sending any **Prescription (Rx)** or **Over The Counter (OTC)** meds for your child to Science School?     Yes     No  
**(Please circle:    Rx     OTC    or Both)**

Note: If bringing Rx meds, you will need to fill out the Prescription Medication Form. Also, instead of sending any of the four OTC medications listed below—per your approval, know that we have a student supply of these in the 24 Hour 1<sup>st</sup> Aid facility.

\_\_\_\_\_ I give permission for the School Teacher or the O.S.S. Nurse to give my child the following OTC medications determined by weight, in case of illness or allergy (we are well stocked with these four OTC meds—there is no need to send them with your child):

\_\_\_\_\_ 1. The correct dosage of Tylenol or equivalent (acetaminophen)     Yes     No

\_\_\_\_\_ 2. The correct dosage of Advil or equivalent (ibuprofen)     Yes     No

\_\_\_\_\_ 3. The correct dosage of Sudafed or equivalent (pseudoephedrine HCL)     Yes     No

\_\_\_\_\_ 4. The correct dosage of Benadryl or equivalent (diphenhydramine)     Yes     No

\_\_\_\_\_ I give permission for the Outdoor Science School to obtain qualified medical or surgical assistance in case of an injury or illness to my child. (Parent/Guardian will be contacted as soon as possible in the event of an emergency.)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mount Hermon Outdoor Science School**  
**Health Emergency Information Form**  
 Page 2 of 2 (+ 3: Prescription Medication Form if applicable.)

**2. Fill out completely. Please explain questions with an asterisk (\*) in space below. If an "In Past" is marked, please put a date next to it.**

**Medical Conditions**

- Bleeding/Clotting Disorder\*  Yes  No  In Past
- Asthma (State Severity)\*  Yes  No  In Past
  - o Inhaler  Yes  No  In Past
- Ear Trouble\*  Yes  No  In Past
- Eye Trouble\*  Yes  No  In Past
- Stomach Aches  Yes  No  In Past
- Tuberculosis  Yes  No  In Past
- Bronchitis  Yes  No  In Past
- Diabetes\*  Yes  No  In Past
- Kidney Disease\*  Yes  No  In Past
- Heart Defects\*  Yes  No  In Past
- Immune-Compromised\*  Yes  No  In Past
- Psychiatric Treatment\*  Yes  No  In Past
- Seizures/Epilepsy\*  Yes  No  In Past
- Sleepwalking  Yes  No  In Past
- Bedwetting  Yes  No  In Past
- Carsickness  Yes  No  In Past
- Menstrual Issues\*  Yes  No  In Past
- Other Medical Conditions\*  Yes  No  In Past

Other Diseases\*  Yes  No  In Past

**Allergies (State severity below.)**

- Hayfever\*  Yes  No  In Past
- Poison Oak\*  Yes  No  In Past
- Any Topical Application\*  Yes  No  In Past
- Medication Allergies\*  Yes  No  In Past
- Bees (State Severity)\*  Yes  No  In Past
- Insects (State Which)\*  Yes  No  In Past
- Nuts (State Which)\*  Yes  No  In Past
- Latex\*  Yes  No  In Past
- Other\*  Yes  No  In Past
- o Carry Epi Pen for any?  Yes  No  In Past

Note: If your child carries an epi pen, please send 2 epinephrine kits with your child. Both will be returned.

Last Tetanus Shot       Last Physical Exam   
 Date \_\_\_\_/\_\_\_\_/\_\_\_\_      Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*Please explain severity and/or any conditions, diseases or allergies marked "Yes" \_\_\_\_\_**

**3. Do you consider your child to be in good health generally?**  Yes  No

**4. Are there any restrictions on your child's physical activity?**  Yes  No

(3 and/or 4) Please describe if so \_\_\_\_\_

**5. Does your child have any severe food allergies? Please list \_\_\_\_\_**

**6. Does your child have any food restrictions (i.e. vegetarian/vegan/religious) or moderate food allergies? Please list \_\_\_\_\_**

Note: The kitchen will do its best to provide for special food needs. However, if your child has extensive dietary needs, please contact your teacher and research the menu as you may need to make food preparations and send them for your child's week at O.S.S.

**Insurance Information**

**\*A front and back copy of parent's insurance card must be included with this form.\***

Name of Insurance Company \_\_\_\_\_ Phone (      ) \_\_\_\_\_  
 Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Group/Policy Number \_\_\_\_\_ Circle One: HMO PPO or Other: \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Name of Child \_\_\_\_\_  
 Name of Physician \_\_\_\_\_ Medical Facility \_\_\_\_\_ Phone (      ) \_\_\_\_\_

**If no Insurance or Health Care Plan exists, please read and sign below.**

I authorize payment of any medical fees to physician or supplier for services described on any attached statements. I hereby authorize any physician who has attended my child or may attend him/her or any hospital where s/he may have been seen as a patient, or any other individual or association who may have given him/her medical treatment or supplies, to disclose any information thus acquired to the Hartford Life and Accident Insurance Company. My consent is hereby granted to use this original or a photo static copy as equally valid authorization.

**Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_**