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 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 1st 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 1st 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 1st 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

Condition			
Bleeding/Clotting Disorder*	☐Yes	☐No	☐In Past
Asthma (State Severity)*	☐Yes	☐No	☐In Past
○ 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.)

Allergy			
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
○ 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 Date_____/______ Last Physical Exam 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___________________

Counselor Name ____________________________ School____

Mount Hermon Outdoor Science School

Health Emergency Information Form

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.

_______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.

Medical Care__________(initials)
I, an adult participant or the parent/guardian of a minor participant, authorize Mount Hermon Association, Inc. to provide or obtain for me such medical care as it considers necessary and appropriate, and I agree to pay all costs associated with such care and transportation. Mediation or Lawsuit:Any dispute between a Released Party and participant or parent/guardian will be governed by the laws of the State of California, and any mediation or suit shall take place only in that State in the County of Santa Cruz.

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 1st 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 1st 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 1st 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—DO NOT 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_______________________

Health Emergency Information Form

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

Condition	Yes	No	In Past
Bleeding/Clotting Disorder*	☐Yes	☐No	☐In Past
Asthma (State Severity)*	☐Yes	☐No	☐In Past
○ 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.)

Allergy	Yes	No	In Past
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
○ 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 Date_____/______ Last Physical Exam 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

Does your child have permission to go swimming? ☐Yes ☐No _______Initial

(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, you may need to make food preparations and send them to camp with your child.

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__________________

Participant/Guardian Waiver Form

Please read this document carefully. It must be signed by all Mount Hermon Outdoor Science School Participants. Since the participant is a minor, at least one parent or guardian must also sign as evidence of their agreement to these terms and conditions on their own behalf and on behalf of the minor.

1. I acknowledge that I have voluntarily applied to participate in the Mount Hermon Outdoor Science School program operated by Mount Hermon Association, Inc. which can be a physically demanding and/or challenging program. Students may participate in standard Outdoor Science School activities with manageable medical conditions. However, if I am participating in the Redwood Canopy Tour Zip-line, I do not have any medical conditions which might create an unsafe risk to myself or others who are participating in this activity with me.

2. Acknowledgement of Risks

I understand that the Mount Hermon Outdoor Science School at Mount Hermon may expose participants to certain risks. The activities require moderate physical exertion and may be conducted at heights up to 150 feet (Redwood Canopy Tour Zip-line). Among the hazards and risks of the activities and use of the premises and equipment are the following: falls; collisions; abrupt and possibly harmful contact with structures, objects and persons; anxieties and fears associated with heights; close contact with other people; coordination and misjudgments on the part of participants; the failure of structures or equipment; and the unpredictable forces of nature. Participants may experience increased heart rate and other symptoms of anxiety and stress due to physical exertion, reliance on other participants, a fear of height, or of unprotected falling, loss of balance, coordination and misjudgments, including failure to follow procedures and instructions, physical or mental or psychological stress, fatigue, chill and /or dizziness which may diminish reaction time and increase the risk of an accident. Injuries associated with participation may include breaks, sprains, bruises, and in extreme cases, emotional upset, anxiety and even death. Participants acknowledge that the description of risks is not complete and that other unknown or unanticipated risks may result in injury, illness or death. Participants acknowledge that this program is purely voluntary, and with full knowledge of the inherent risks of the activities.

3. Assumption of Risks

I understand that participation in the Mount Hermon Outdoor Science School entails certain risks. I am voluntarily participating in this program with knowledge of the risks involved. I hereby accept any and all risks of injury or death to myself or any minor children for which I am responsible, arising out of or in any way connected with the use of the program, the Mount Hermon Adventure facilities, and/or one of affiliated organizations of Mount Hermon Association, Inc.

4. Release and Indemnity

As consideration for being permitted to participate in the Mount Hermon Outdoor Science School, I hereby agree that I, my assignees, heirs, and/or as the parent/guardian of a minor participant, will release and hold harmless and not bring any claim or legal suit against Mount Hermon Association, Inc., its directors, managers, officers, agents, employees and volunteers or its affiliated organizations or the supplier of any of the equipment used in the activity (“Released Parties”), for any and all claims of injury, disability, death or other loss or damage to person or property suffered by me or my minor child arising in whole or in part from participation in this program, both foreseeable or unforeseeable.

In addition, I agree TO INDEMNIFY (that is, defend and satisfy by payment or reimbursement, including costs and attorney’s fees) Released Parties from any claim of loss, injury or death, brought on by myself or my child against another co-participant. These agreements of release and indemnity include loss or damage caused or claimed in whole or in part by the negligence of a Released Party, but not intentional wrongs or the gross negligence of a Released Party.

I HAVE CAREFULLY READ THIS VOLUNTARY PARTICIPATION AGREEMENT FORM AND PARTICIPANT REQUIREMENTS AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY IN WHICH I AM GIVING UP IMPORTANT LEGAL RIGHTS AND A CONTRACT BETWEEN MYSELF AND MOUNT HERMON ASSOCIATION, INC. AND/ OR ITS AFFILIATED ORGANIZATIONS, AND SIGN IT OF MY OWN FREE WILL.

Print Parent/Guardian Name	**Signature**	**Date**

Cabin Leader/Counselor Name	**Signature**	**Date**