

Mount Hermon Outdoor Science School
Homeschool Health Emergency Information Form
Participant Form

*Make enough copies to fill out for all of your participants. Please fill this form out for EVERY child that you are responsible for that will be participating in either our **CLASSES** (K through 12th Grade) or our **DAYCARE** (0-4 years old) programs. If there are other persons in your care (including you) that will not be participating in classes or daycare, please copy and fill out the **Non-Participant Form** as needed. Thank you!

1. Participant's Name _____ Birth Date ____/____/____ Male____ Female_____

Health Information

2. Fill out completely for participating child. *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 for the classes.

Last Tetanus Shot _____ Last Physical Exam _____
 Date____/____/____ Date____/____/____

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

3. Do you consider the participating child to be in good health generally? Yes No

4. Are there any restrictions on the participating child's physical activity? Yes No

(3 and/or 4) Please describe if so _____

5. Does the participating child have any severe food allergies? Please list _____

6. Does the participating child have any food restrictions (i.e. vegetarian/vegan/religious) or moderate food allergies? Please list _____

Consent for Specific Medications: I give permission for the O.S.S. Director, First Aid Technician or the O.S.S. Nurse to give my child the following **correct dosage** of OTC medications determined by weight, in case of illness or allergy if parent is not present:

- 1. Tylenol or equivalent (acetaminophen) Yes No
- 2. Advil or equivalent (ibuprofen) Yes No
- 3. Sudafed or equivalent (pseudoephedrine HCL) Yes No
- 4. 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.) Yes No

Parent/Guardian Signature _____ Date _____