

OMSI Outdoors Health and Medical Form

All students and adults participating in OMSI Outdoors programs must fill out this form completely. Return this form to your teacher/group leader as early as possible. PLEASE PRINT CLEARLY IN BLUE OR BLACK INK. Note: teachers and chaperones are responsible for all medical issues at Outdoor Science School. A "Health Officer" (usually the teacher) is responsible for all medical and insurance information for each student and adult, collecting all medication and ensuring that each student receives medications as prescribed.

Participant Information

Participant Name: _____ DOB and Age: _____
 Parent/Guardian: _____ Home Phone: _____
 Street Address: _____ Work Phone: _____
 City, State, Zip: _____ Home Email: _____
 Work Email: _____

Emergency Contact: _____ Home Phone: _____
 Relationship: _____ Work Phone: _____

Health and Medical History

Please check if participant is subject to the following and include explanation.

- | | | | | |
|------------------------------------|--|--|-------------------------------------|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Allergy | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Bee Sting | <input type="checkbox"/> Blindness | <input type="checkbox"/> Deafness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Other | | | | |

Explanation: _____

List all current medications, time(s) taken, and for what condition(s): _____

List any allergies to medications, the reaction, and the severity: _____

List any past medical conditions, injuries, or medial illnesses that might affect the program, including any restrictions of activity for medical reasons: _____

Date of last tetanus inoculation. MUST BE WITHIN LAST 10 YEARS. (If your child was immunized before attending school, he or she received a tetanus shot at age 5.): _____

Describe any behavior problems or habits that would be disruptive to group learning: _____

List any dietary restrictions (please be specific e.g., vegetarian, no pork, etc.): _____

List allergies to any foods, the reaction, the severity, and the amount tolerated (e.g., "no raw milk/cheese but ok in baked goods"): _____

Do you authorize the Health Officer to dispense over the counter drugs, such as Tylenol, Advil, or Benadryl if you are not reachable to give immediate permission? Yes No

Provider Information:

Doctor's Name: _____ Phone: _____
 Insurance Company: _____ Agent name: _____
 Insurance Address: _____ Policy Number: _____
 City, State, Zip: _____

My child has my permission to participate in all sessions and field trip activities. I am this child's parent or legal guardian, who is under the age of 18 years and who wants to participate in OMSI's programs. In consideration of my child's or ward's participations in the programs, I hereby release, waive, and discharge OMSI, and all of its instructors, employees, officers, directors, agents, and volunteers from any and all liability to me, to my child or ward, and to all my legal representatives, assigns, heirs, and next of kin for damage and injury to my child or ward or to any person or property arising out of participation in the program, whether on OMSI's premises or elsewhere. This agreement includes but is not limited to claims or demands on account of injury or damage caused or allegedly caused by the negligence of OMSI or any of the individuals listed above.

Adult Participant or Parent/Guardian Signature: _____ Date: _____