



GLEN HELEN OUTDOOR SCHOOL HEALTH FORM

To be completed for all students attending Glen Helen Outdoor School

School: _____ Grade Level: _____
 Child's Name _____ Gender: _____
 Date of Birth: _____ Age: _____
 Address: _____
 Parent/Guardian 1: _____ Guardian at the Address Above? Y / N
 Relationship to Child: _____ Phone Number(s): _____
 Parent/Guardian 2: _____ Guardian at the Address Above? Y / N
 Relationship to Child: _____ Phone Number(s): _____
 Emergency Contact Other Than Parent/Guardian: _____
 Relationship to Child: _____ Phone Number(s): _____

Allergies and Dietary Restrictions

Does your child require an EpiPen? Y / N

If yes, please provide details about your child's anaphylaxis, including date & description of last reaction: _____

If your child requires an EpiPen, please provide two non-expired EpiPens: one for your child to carry with them and one to keep in the cabin.

Please list any food, medicine/drug, and/or environmental allergies.(Please include reactions.)

Does your child have any dietary restrictions (please note here if your child is vegetarian or vegan) or food sensitivities? If so, please explain:

Health History

Child's Physician: _____ Phone Number: _____

Date of Last Visit: _____ Are Immunizations up to date? Y / N

Please Check All Past and Present Health Concerns

- | | | |
|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma/Inhaler |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Behavioral Issues |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart Disease/Defect |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Mental Health Considerations | <input type="checkbox"/> Muscular Disorder |
| <input type="checkbox"/> Nightmares/Terrors | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other: _____ | |

Please explain the above health concerns:

Immunizations, Restrictions & Concerns

If your child is up to date on immunizations required for school attendance please list the date (or approximate dates) of your child's most recent vaccination or booster, if any, for the following:

Hep B _____ Tetanus _____

If your child has not been fully immunized, please explain:

Has your child been exposed to any communicable diseases within the last three months? If yes, please explain what disease(s) your child has been exposed to and when exposure occurred:

Does your child have any restrictions on activity? If yes, please explain what activities must be restricted and list any accommodations that should be made:

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

Medications and Treatments

Will your child be taking any prescription medication while at Outdoor School? Y / N

Will your child bring any non-prescription medication while at Outdoor School? Y / N

If you've answered yes to either of the above questions, please complete the Outdoor School Medical Administration Form and send your child's medications in the appropriate manner.

The Outdoor Education Center's first aid cabinet is stocked with first aid supplies, over-the-counter medications, and treatments for minor afflictions. Is there anything Outdoor School staff needs to be aware of when giving any of the approved over-the-counter medications to your child?

May the following over-the-counter medications be given to your child while at Outdoor School (please select Y / N for each)

Y / N - Acetaminophen (Tylenol)	Y / N - Bug Spray
Y / N - Allergy / loratadine	Y / N - Burn Ointment
Y / N - Antacids (Alka-Seltzer/Tums)	Y / N - Calamine Lotion
Y / N - Anti-Itch or Antifungal Cream	Y / N - Cough Drops
Y / N - Antibiotic Cream/ Antibacterial Ointment	Y / N - Cough Relief
Y / N - Antihistamines (Benadryl, diphenhydramine)	Y / N - Ibuprofen (Advil)
Y / N - ASA (Aspirin)	Y / N - Nasal Decongestant
	Y / N - Pepto Bismol
	Y / N - Sunscreen

Insurance Information

Is this child covered by medical insurance? Y / N

Full Name of Policy Holder: _____ Policy Holder Phone: _____

Insurance company / plan name: _____

Insurance Co. Phone: _____ Insurance policy number: _____

Health insurance group name / number: _____

MEDICAL WAIVER AND CONSENT FOR TREATMENT

Signature is 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 give my informed consent to the following:

- Teachers or administrators of my child's school and Glen Helen Outdoor Education Center staff and interns may provide basic First Aid and comfort measures through standardized camp treatment procedures which include the use of over-the-counter medications as I have approved.
- 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, any of whom may sign all documents necessary to obtain such treatment; medical personnel selected by any teacher or administrator of my child's school or school district or by the Outdoor Education Director may order x-rays, routine tests, treatments, and necessary transportation for this child.
- In the event I cannot be reached in an emergency, I hereby give permission to the physician selected to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child, and I do assume all responsibility for payment for such treatment.

I understand the information on this form will be shared on a "need to know" basis with Glen Helen staff. I give permission to photocopy this form. In addition, attending school staff and the Outdoor Education Director has permission to obtain a copy of this child's health record from providers who treat the child and these providers may talk with the program's staff about the child's health status. Please read and sign that you have read the Medical Waiver and Consent for Treatment above, and that you understand it and agree to be bound by it:

Signature of Parent or Legal Guardian: _____

Printed Name: _____ Date: _____

GLEN HELEN OUTDOOR SCHOOL RELEASE AND LIABILITY WAIVER

Signature is required for attendance.

Glen Helen Association, its Glen Helen Nature Preserve and Glen Helen Outdoor Education Center, and all Outdoor School staff and volunteers ("Releasees") are committed to conducting outdoor programs and activities in a safe manner. As program staff, we attempt to reduce risks and insist that all program participants and visitors follow program safety rules and instructions.

Assumption of Risk

I, in my legal capacity as parent/guardian of the minor named below ("Minor"), acknowledge and agree that any use of Glen Helen Association's facilities, services, equipment and premises ("Facilities") and any participation in Glen Helen Association's programs and activities ("Programs") comes with risks, including ordinary negligence of any Releasee, including but in no way limited to: (1) moderate and severe personal injury, (2) property damage, (3) disability, (4) death, and (5) sickness or disease including, without limitation, COVID-19. I understand that there is risk in participation in any outdoor recreational activity and that not all hazards and dangers can be foreseen. I recognize and acknowledge that it is impossible for Glen Helen Association staff to guarantee absolute safety, and I still desire for my child to participate in Glen Helen Association's Outdoor School program, being fully aware there are such risks. I expressly agree to assume all risks of participation on behalf of myself and my minor child.

Release, Waiver & Covenant Not to Sue

In consideration of Minor's use of Facilities and participation in Programs I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor that Glen Helen Association, its officers, directors, agents, employees, volunteers, insurers and representatives ("Releasees") will not be liable for any personal injury, property damage, disability, death, sickness or disease incurred by Minor, however occurring including, but not limited to, the negligence of Releasees. I understand that Minor and I will be solely responsible for any loss or damage, including personal injury, property damage, disability, death, sickness or disease sustained from the use of Facilities and participation in Programs.

I further agree, in my legal capacity as the parent/guardian of Minor, on behalf of Minor, myself, and any and all legal successors and proxies, to release and HEREBY DO RELEASE, WAIVE AND COVENANT NOT TO SUE Releasees from any causes of action, claims, suits, liabilities or demands of any nature whatsoever including, but in no way limited to, claims of negligence, which Minor, myself, and any and all legal successors and proxies may have, now or in the future, against Releasees on account of personal injury, property damage, disability, death, sickness, disease or accident of any kind, arising out of or in any way related to the use of Facilities or participation in Programs, whether that participation is supervised or unsupervised, however the injury or damage occurs, including, but not limited to, the negligence of Releasees.

I understand that the parent/guardian is fully responsible for the child's transportation if they are dismissed for disciplinary, behavior, or medical reasons.

In further consideration of the use of Facilities and participation in Programs and having carefully read this waiver and release, I, in my legal capacity as parent/guardian of Minor, understand by signing below I am assuming all risks of participation and I am giving up the right to bring a legal action or assert a claim for injury or loss of any kind against Glen Helen Association.

Participating Minor's Name: _____

Signature of Parent or Legal Guardian: _____

Printed Name: _____ Date: _____

GLEN HELEN OUTDOOR SCHOOL PHOTO RELEASE FORM

Glen Helen staff and interns may take photos and/or videos of students participating in camp activities for the purposes of marketing in print, electronically, or on the Internet. Students will not be identified by name without further authorization from a parent/guardian.

I give Glen Helen Association permission to publish in print, electronic, or video format the likeness or image of my child.

I release all claims against Glen Helen Association with respect to copyright ownership and publication including any claim for compensation related to use of the materials.

Signature of Parent or Legal Guardian: _____

Printed Name: _____ Date: _____

GLEN HELEN OUTDOOR SCHOOL MEDICATION ADMINISTRATION FORM

If your child is coming with any medication, vitamins or supplements, this form must be completed in full.

Child's Name _____

To be filled in by school staff:

Trail Group _____ Dorm _____

Guidelines

- All prescription medications will be given as directed on the original package/container. If there are any dosage or schedule adjustments, differing from the original prescription, you must bring signed documentation from your physician.
- A physician's signature is also required for all non-prescription medications that are to be administered at a ***different*** dosage or schedule than recommended by the drug manufacturer.
- Medications must be in their original containers with the child's name, dosage and schedule listed.
- Bring medications in a clear zip lock bag clearly labeled with your child's name.

Please list all prescription and non-prescription medications being brought to Glen Helen (continues on back):

1. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____

2. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____

3. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____ Phone Number _____

For Prescribing Physician (Complete only if needed)

I have approved the above information regarding prescription medications changes or non prescription medications with dosage variations.

Physician's Signature _____ Date _____

Physician's Printed Name _____ Phone Number _____

- 4. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____

- 5. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____

- 6. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____

- 7. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____

- 8. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____

- 9. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____

- 10. Name of medication: _____
Purpose of medication: _____
Dosage and dispensing times: _____
