NAME OF CAMP______________________DATES OF CAMP__________ALLERGIES? ______Today's Date_____

CU Science Discovery Wilderness Camps
Student Health and Emergency Information – Please complete in FULL as required by licensing.

Student Name (first and last) ____ circle: M F

D.O.B.(mm/dd/yyyy) ____________ Age ______ Grade in 2008-09 ______ School, District______________

Student lives with (please circle) mother, father, both parents, other ______________________________

Parent/Guardian (first and last name)

1.) ____Relationship _______Phone ____________

Email _____________________Home Address (street, city, state, zip)___________________________

Place of Employment
____Work/Cell Phone________________________

Street Address of Employment ____________________________City ______________Zip _________

2.) ____Relationship _______Phone ____________

Email _____________________Home Address (street, city, state, zip)___________________________

Place of Employment
____Work/Cell Phone____________________________

Street Address of Employment ____________________________City ______________Zip___________

This section MUST be completed.
EMERGENCY CONTACTS. Adults I authorize to pick up my child should I not be available:
1.) NAME__________________________________ Complete Address/Zip _____________________

Work Phone ________________ Home Phone ________________ Cell Phone ___________________

2.) NAME__________________________________ Complete Address/Zip ______________________

Work phone ________________ Home Phone _________________ Cell Phone __________________

3.) NAME__________________________________ Complete Address/ZIP ______________________

Work Phone _________________ Home Phone _________________Cell Phone __________________
Persons who may NOT pick up my child ____

PERMISSION TO PARTICIPATE
I have seen an overview of activities for the camp in which I have voluntarily enrolled my child. I give permission for my child **to participate in all of the scheduled activities. If I disagree,** I have listed below the activities in which my child may not participate, understanding he/she will accompany the group.
Parent comment: _______________________________________ Parents please initial _____________

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HEALTH and MEDICAL INFORMATION for Student Full Name ________________________________

Please attach the following:
- Signed confirmation from child's doctor of a physical within the last 24 months of camp.
- Copy of current immunization records.

Overall health _____________ Date of last physical ___________ Last tetanus shot _____________

Doctor _______________________ Complete Address/Zip _____________________ Phone_______

Insurance with _______________________________ Policy Number _________________________

Does your child have allergies to (CIRCLE): FOOD, INSECTS, MEDICATIONS, OTHER?
In order to help us provide the best care for your child, please provide ***DETAILED*** information.

____

____

Does your child carry a prescribed inhaler? _______________ Epi-pen?_________________
✭ A doctor's signature will be required for these items ✭

Please explain any past serious illnesses or hospitalizations. _________________________________

____

What phobias or fears does your child exhibit? ____

Please describe any known limitations or special needs your child has:

____

I have given the most current information available requested on this form. I will contact the Science Discovery office should there be any changes that would affect my child's safety while involved in this experience including changes in my address and emergency contact information.

I give Science Discovery (SD) Staff permission to provide basic first aid to the level of their training and to assist my child in administering medications per attached written instructions. I give permission for SD staff to seek emergency medical treatment should the need arise and I am not available for consultation. I understand that any medical expenses incurred are my financial responsibility.

____ Date ________________
Parent/Guardian Signature

This information is only to assist us in an emergency.

Height ______ Weight _______ Eye Color ______ Hair Color ______

Birthmarks ________ Tatoos ___________ Piercings ____________

Other Pertinent Info ___________________________________

Photo Here
Or attach a separate sheet with photo.

Please use a recent photo
Within 6 months, if possible

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MEDICATION INFORMATION for Student Full Name ___________________________________

Include prescribed, homeopathy, sunscreen, injections, cold meds, over the counter, etc.

- Medications **MUST** be kept in **ORIGINAL container** with patient name, dosage, etc. Put meds in a **seal-able plastic bag, labeled with your child's name** and camp.
- We **MUST** have your ***DOCTOR'S WRITTEN PERMISSION*** to assist your child in taking his/her PRESCRIBED medication. ***Science Discovery will carry all meds*** unless noted otherwise.

1.)____

Dosage and time to be administered

____

Possible side affects

____

Storage directions

____

Indicate medical consequences of child missing his/her medication at specified time.

____

2.)____

Dosage and time to be administered

____

Possible side affects

____

Storage directions

____

Indicate medical consequences of child missing his/her medication at specified time.

____

3.)____

Dosage and time to be administered

____

Possible side affects

____

Storage directions

____

Indicate medical consequences of child missing his/her medication at specified time.

____

Physician's Signature ________________________________ Date _____________

Print Name of Physician ___________________________ Phone _____________