

Birth Date \_\_\_\_\_ Child's Name \_\_\_\_\_

Date attending GBOS \_\_\_\_\_ Teacher's Name \_\_\_\_\_

## Health Inventory

### *Contact Information*

Custodial Parent/Guardian \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Second parent, if needed \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Is there a custody agreement we should be aware of? NO YES (if yes, attach additional information)

Emergency contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

NOTE: We are authorized to release the child only to the contacts listed above unless a note from the custodial parent/guardian states otherwise.

### *Family Doctor*

Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Religious Preference \_\_\_\_\_

### *Insurance*

The following insurance information is required if a doctor visit or entry into a hospital is necessary:

Do you have Health Insurance Coverage? YES NO

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Name Listed on the Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

### *Medications*

Will your child be taking *prescription* medication while at the Outdoor School? NO YES

If yes, have your doctor fill out and sign the **GBOS Prescription Medication Authorization** and attach to this form. Prescription meds will be stored in a secure area and given by the classroom teacher.

Will your child be bringing or taking *over-the-counter* medication while at the Outdoor School? NO YES

If yes, fill out and sign the **GBOS Over-the-Counter Medication Authorization** and attach to this form.

Over-the-counter meds will be stored in a secure area and self-administered by the child, under supervision of the classroom teacher.

## Health Conditions

	Yes		Yes		Yes
1. Asthma/inhaler		8. Diabetes		16. Recent illness or injury	
2. Life threatening reaction to bee stings or insect bites		9. Epilepsy/seizures		17. Recent exposure to contagious disease	
		10. Chronic illness			
3. Epi-pen		11. Depression		18. Car sickness	
4. Severe allergy to medication		12. Hearing problems		19. Sleepwalking	
5. Severe allergy to food		13. Vision problems		20. Bed wetting	
6. Other severe allergies		14. Wear glasses/contacts		21. First time away from home or overnight?	
7. ADD or ADHD		15. Eating disorders			

Please provide details for each checked box, being as specific as possible:

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Are there other medical or social concerns that would assist us in providing a supportive and rewarding experience at GBOS? \_\_\_\_\_

Immunizations up to date? YES NO Date of last tetanus inoculation \_\_\_\_\_

List any DIETARY restrictions \_\_\_\_\_

Is your child a vegetarian? YES NO

List any ACTIVITY restrictions \_\_\_\_\_

### Parent Authorization

A parent/guardian SIGNATURE is REQUIRED for anyone under 18 to receive medical treatment.

I verify that this Health Inventory is correct and complete to the best of my ability. The person named above has permission to participate in all GBOS activities except as noted. I understand that my child may walk as much as 5 miles a day and that exposure to natural features such as sun, wind, insects, and uneven walking surfaces will be encountered and are not under the control of GBOS.

For the duration of the GBOS program, I also give my permission to GBOS to provide routine first aid and care and to seek emergency medical treatment. I agree to the release of any records for insurance purposes. I give permission to GBOS to arrange necessary related transportation for treatment.

In the event I cannot be reached in an emergency, I authorize the appropriate health care provider selected by GBOS or the classroom teacher to administer any necessary medical, surgical, and/or hospital care while the person named above is attending and/or en route to and from the Great Basin Outdoor School.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

If you do not want medical care given to your child, do not sign above, and please briefly state your reason(s) below:

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