

Child's Name _____ Birth Date _____

Dates Attending GBOS _____ Teacher's Name _____

Emergency Information (student)

Contact Information

Address _____

Email _____

Custodial Parent/Guardian Name _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Second Parent (if needed) Name _____

Home Phone _____ Work Phone _____ Mobile Phone _____

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.

Is there a custody agreement we need to be aware of? YES NO (If yes, attach additional information)

Family Doctor

Doctor's Name _____ Phone Number _____

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

PRESCRIPTION and/or OVER-THE-COUNTER MEDS for a specific diagnosis	YES	NO
Will your child be taking prescription and/or over-the-counter medication for a specific diagnosis while at GBOS?		
Have you filled out a medication consent form for these medications? Your child's teacher can store & provide meds as needed during your child's stay at GBOS.		
Other OVER-THE-COUNTER MEDS	YES	NO
Will your child be bringing and self-administering other over-the-counter medication? Your child's teacher can store "just-in-case" over-the-counter meds and provide as needed.		

Health Conditions

	YES		YES		YES
1. Asthma/Inhaler		7. Diabetes		13. Recent Illness or Injury	
2. Life Threatening Reaction to Bee Stings or Insect Bites		8. Epilepsy/Seizures		14. Recent Exposure to Contagious Disease	
3. Epi-Pen		9. Chronic Illness		15. Car Sickness	
4. Severe Allergy to Medication		10. Hearing Problems		16. Sleep Walking	
5. Severe Food Allergy		11. Vision Problems		17. Wear Glasses/Contacts	
6. Other Severe Allergies		12. Eating Disorder		13. ADD or ADHD	

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

Have you notified the school nurse of any recent changes in your child's health aside from information you provided on the Student Health Information form at the beginning of the school year? YES NO

Is your child a vegetarian? _____ Are there any other special food needs? _____

Are there any activity restrictions? _____

Are there any other concerns that would assist us in providing a supportive and rewarding experience?

Parent Authorization

A parent/guardian SIGNATURE IS REQUIRED for anyone under 18 to receive medical treatment. I verify that this Student Emergency Information is correct and complete to the best of my ability. My son/daughter 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.

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 if needed. 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 even 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 student named above is attending and/or en route to and from the Great Basin Outdoor School.

Signature of Parent/Guardian

Date