

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

Dates Attending GBOS \_\_\_\_\_ Teacher's Name \_\_\_\_\_

## Emergency Information (for WCSD 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**

<b>PRESCRIPTION and/or OVER-THE-COUNTER MEDS for a specific diagnosis</b>	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 WSCD medication consent form for any medications that should be administered by the WSCD staff during your child's stay at GBOS?		
If yes, have you contacted the school's health office and spoken to the school nurse about your child's medication needs and the WSCD policies for the administration and supervision of the medication?		
<b>Other OVER-THE-COUNTER MEDS</b>	YES	NO
Will your child be bringing and self-administering other over-the-counter medication while at GBOS?		
If yes, have you contacted the school's health office and spoken to the school nurse about the WSCD policies for carrying, storing and self-administering medication at GBOS?		

Have you notified the school nurse regarding any recent changes in your child's health status aside from the 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 for Emergency Medical Treatment**

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. The student 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 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