

GLEN HELEN OUTDOOR EDUCATION CENTER ECOCAMP HEALTH FORM

Camp Name(s) _____ Camp Week #(s) _____

PERSONAL INFORMATION

Child's Name _____ Birthdate _____ Age _____ Sex _____

Street Address _____

City _____ State _____ Zip Code _____

Parent/Guardian 1 _____ Does this parent reside at the address listed above? **Y / N**

Phone (H) _____ Phone (C) _____ Phone (W) _____

Parent/Guardian 1 _____ Does this parent reside at the address listed above? **Y / N**

Phone (H) _____ Phone (C) _____ Phone (W) _____

Emergency contact other than Parent/Guardian _____

Relationship to Child _____ Phone(s) _____

HEALTH HISTORY

Child's Physician _____ Phone _____

Date of last visit _____ Date of last Tetanus shot _____

Is your child up to date on all immunizations required for Ohio public school attendance? _____

Please Check All Past and Present Health Concerns

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> Heart Disease/Defect | <input type="checkbox"/> Muscular Disorder | <input type="checkbox"/> Ulcers |

Please explain the above health concerns. _____

Please list allergies (food, drug, other) and reactions. _____

Please explain any recent infectious disease. _____

Does your child have any dietary restrictions or special needs? _____

Is there any reason why your child should follow a limited schedule of physical activity? _____

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

MEDICAL INSURANCE

Name of Medical Insurance Company _____

Phone Number _____ Address _____

Name of Policy Holder _____

Policy Number _____ Group Number _____

MEDICATIONS

IF YOUR CHILD IS COMING WITH ANY MEDICATIONS, PLEASE COMPLETE THE MEDICATION ADMINISTRATION FORM. A PHYSICIAN'S SIGNATURE MAY BE REQUIRED.

IMPORTANT: The Outdoor Education Center's first aid cabinet is stocked with first aid supplies, over-the-counter medications, and treatments for minor afflictions. Are there any over-the-counter medications or treatments that your child may **NOT** have due to allergy or parental/guardian preference? _____

PARENT/GUARDIAN AUTHORIZATION (signature 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 consent to the following:

- authorization for consent for treatment may be given by the Outdoor Education Center Director or Assistant Director, either of whom may sign all documents necessary to obtain such treatment;
- the administration of any and all necessary medical treatment by a licensed physician or dentist either at his/her office or at a hospital;
- and the transfer of the minor, if necessary, to a specialty hospital, such as a Children's Hospital.

I understand that the parent/guardian is fully responsible for the child's transportation if he/she is dismissed for disciplinary, behavior, or medical reasons. I absolve Glen Helen Outdoor Education Center and all of its employees of any and all liability, financial and/or otherwise arising from participation in the Outdoor Education Center program and/or the administration of medication to the child named herein under the terms of this release. I understand that Glen Helen Outdoor Education Center is not responsible for payment for any medical expenses incurred during participation in the program.

Signature of Parent or Legal Guardian _____ **Date** _____