Wilderness Journeys • Summer 2015
Experiential Learning Associates

Experiential Learning Associates
Youth | Teachers | Science | Leadership

Student Health and Emergency Information – Please complete in FULL
Licensing regulations require us to collect and have this information with us during the trip

Student FIRST NAME_____ LAST NAME _____

Male Female (*Please Circle)* D.O.B.(mm/dd/yyyy) _____ Age during trip _____

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 _____State _____ Zip _____

2.) _____Relationship _____Phone _____

Email _____Home Address (street, city, state, zip)_____

Place of Employment _____Work/Cell Phone_____

Street Address of Employment _____City _____State _____ Zip _____

~~~~~~~~The section below MUST be completed in full~~~~~~~~

EMERGENCY CONTACTS. Adults I authorize to pick up my child should I not be available:

1.) NAME/Relationship_____ Complete Address/Zip _____

Work Phone _____ Home Phone _____ Cell Phone _____

2.) NAME/Relationship_____ Complete Address/Zip _____

Work Phone _____ Home Phone _____ Cell Phone _____

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Persons who may NOT pick up my child _____

1.) NAME/Relationship_____ Complete Address/Zip _____

Work Phone _____ Home Phone _____ Cell Phone _____

2.) NAME/Relationship_____ Complete Address/Zip _____

Work Phone _____ Home Phone _____ Cell Phone _____

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

Student Full Name _____**Today's Date** _____

For Emergency Purposes Only (optional but preferred)
Height _____ Weight _____ Eye Color _____ Hair Color _____
Birthmarks _____ Tatoos _____ Piercings _____
Other _____

Please attach a recent photo of your child (recommended)

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Doctor's Name _____

Complete Address/Zip _____ Phone_____

Dentist Name _____

Complete Address/Zip _____ Phone_____

Preferred HOSPITAL if needed _____

_____ IMMUNIZATION RECORD REQUIRED – Please attach_____

Overall health _____

Date of last physical _____ **Last tetanus shot** _____

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Please complete the following even if you have given this information online so we are certain of any recent developments:

Allergies to: FOOD? INSECTS? SEASONAL? OTHER?

_____

Prescribed inhaler? YES • NO Please explain including any hospitalizations

_____

Epi-pen? YES • NO Briefly explain the nature of the allergies and any hospitalizations

_____

Pertinent recent hospitalizations, surgeries or chronic medical issues

_____

List known limitations, fears, phobias or special needs _____

I give permission for staff to administer ibuprofen for headache or minor condition.

YES _____ NO _____ Other info we should know _____

Insurance _____ Policy Number _____Phone _____

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MEDICATION INFORMATION for Student Full Name

NAME _____CAMP _____DATE _____

My child will need the following during this trip:
_____ Prescribed medications – I will have doctor's orders with a signature.
_____ Over the counter medications – I will send only what is needed with specific directions
_____ Sunscreens with specific instructions

- Medications **MUST** be kept in **ORIGINAL LABELED CONTAINER** (child's name, name of med, instructions for giving meds, pharmacy contact info). We cannot accept medications in any other container.
- **YOUR DOCTOR'S signature with instruction is required!**

MEDICATION 1.)_____pill, ointment/salve?_____

Dosage and time to be administered _____

Possible side affects _____

Refrigeration Needed? Yes No Storage Instructions _____

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

_____

MEDICATION 2.)_____pill, ointment/salve ?_____

Dosage and time to be administered _____

Possible side affects _____

Refrigeration Needed? Yes No Storage Instructions _____

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

_____

Please use additional sheet if sending more than 2 medications

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PHOTO RELEASE, DAMAGE, LOSS, THEFT, REFUND AND CANCELLATION POLICY
I have signed off on the above when I registered and I intend to, or have already, contacted the ELA office with changes.

The information I have completed on this form is true and accurate. I understand that withholding pertinent health and medical information could negatively affect my child and others on the trip. I will contact ELA should there be any changes that would affect my child's safety while involved in this experience including changes in my personal and emergency contact information. I give ELA 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 ELA 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.

Parent/Guardian Signature _____ Date _____

Thank you for completing this form!