

Sutter County Office of Education -- Shady Creek Outdoor School Program  
Counselor Registration and Health Form

**TO BE COMPLETED BY PARENT OR GUARDIAN**

Student Name _____ (Last)            (First)            (Nickname)	Birthdate _____	Grade _____	Gender _____
Teacher's Name _____		School _____	
Home Address (Street) _____		City/Zip _____	
Mailing Address (if different) _____		Home Phone _____	
Father's Name _____	Place of Work _____	Phone _____	
Mother's Name _____	Place of Work _____	Phone _____	
Emergency Name _____	Relationship _____	Phone _____	
Physician's Name _____	Office Address _____	Phone _____	

**GENERAL HEALTH INFORMATION**

Check ALL applicable conditions of student and explain below

**IMPORTANT:**

**Is your child bringing prescription or non-prescription medication to the site?**            Yes \_\_\_ No \_\_\_

If "Yes", then you must complete the Medication Authorization Form to send with the medication.

**Has your child been exposed to any communicable disease within the past month?**            Yes \_\_\_ No \_\_\_

If "Yes", please specify the disease. \_\_\_\_\_

**Date of last known Tetanus Shot:** \_\_\_\_\_ **Is your child a vegetarian?** Yes \_\_\_ No \_\_\_

Yes No (Please check yes or no for each item)			
<b>A. ALLERGIES</b>		I. Heart Condition <input type="checkbox"/> yes <input type="checkbox"/> no	
Bee Stings/Insect Bites <input type="checkbox"/> yes <input type="checkbox"/> no		J. Nose Bleeds <input type="checkbox"/> yes <input type="checkbox"/> no	
Food _____ <input type="checkbox"/> yes <input type="checkbox"/> no		<b>K. Recent Broken Bone or other injuries</b> <input type="checkbox"/> yes <input type="checkbox"/> no	
Hay Fever <input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> no            Body part injured _____    Injury Date _____	
Other _____ <input type="checkbox"/> yes <input type="checkbox"/> no		(Describe All Activity Restrictions on other side)	
<b>B. Asthma</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>L. Recent Surgery</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
Bringing Medication? <input type="checkbox"/> yes <input type="checkbox"/> no		Body Part _____    Date of Surgery _____	
<b>C. Back or Neck Problems</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	(Describe All Activity Restrictions on other side)	
<b>D. Bedwetting (currently)</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>M. Sinus Problem</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>E. Bowel Problems</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>N. Sleep Walking (history of)</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>F. Epilepsy or seizure disorder</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>O. ADD or ADHD (attention deficit disorders)</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>G. Fainting</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	_____ Bringing Medication?	
<b>H Headache</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>P. Diabetic</b>	<input type="checkbox"/> yes <input type="checkbox"/> no

Briefly explain ALL items checked above (refer to each item by letter) and explain any other medical issues not listed above (use additional sheets if necessary). Please also disclose any medically necessary dietary requirements. \_\_\_\_\_

Allergies: Specify type(s), child's reaction, and authorized treatment(s): \_\_\_\_\_

Asthma/ADD/Insulin/Epi-kits: Any prescribed medicine or inhaler must be sent to Shady Creek Outdoor School for student's use under supervision. All medications must be sent in their original prescription container and be accompanied by an authorization form signed by the parent and prescribing physician.

**Non-Prescription Medication at Shady Creek Outdoor School:**

Occasionally, it is necessary to provide students with non-prescription medications when they are at the site. The medications listed below are kept in stock at the site for this purpose. Please do not send any of these items to the site. Please check below to indicate whether you give permission for the listed medication to be administered by the School Nurse, Health Technician or an authorized responsible staff member. We will not administer any medication without authorization.

- |                              |                             |   |                              |                             |                                       |
|------------------------------|-----------------------------|---|------------------------------|-----------------------------|---------------------------------------|
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Advil (dysmenorhea) (for fever or pain) | <input type="checkbox"/> yes | <input type="checkbox"/> no | Tylenol (head/muscle aches)           |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Benadryl (localized itch/insect bite)   | <input type="checkbox"/> yes | <input type="checkbox"/> no | Kaopetate (diarrhea)                  |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Caladryl Lotion (poison oak)            | <input type="checkbox"/> yes | <input type="checkbox"/> no | Actified/Sudafed (nasal congestion)   |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Mylanta (upset stomach)                 | <input type="checkbox"/> yes | <input type="checkbox"/> no | Neosporin Ointment (minor cuts/burns) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Cough Drops (cough)                     | <input type="checkbox"/> yes | <input type="checkbox"/> no | Robitussin (cough)                    |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Cortisone .5% Cream (itch/rash)         | <input type="checkbox"/> yes | <input type="checkbox"/> no | Dramamine (motion sickness)           |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Rid/Nix (lice treatment)                |                              |                             |                                       |

**Authorization For Medical Treatment - SIGNATURE REQUIRED OR STUDENT CANNOT BE TREATED:**

I hereby authorize emergency medical or surgical care at the nearest hospital, should a medical emergency arise and I am not immediately available. I further authorize site personnel to assist my child in the use of the medications indicated above and those listed on the attached Medication Authorization Form.

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

\_\_\_\_\_  
Date

**Discipline Policy Statement**

Please be advised that all rules of the students school apply while at the outdoor school. And all such consequences will be the same as if attending classes at the home school.

**I have reviewed the above rules with my child and agree to pick him/her up at Shady Creek Outdoor School if called upon to do so.**

Parent Signature: \_\_\_\_\_ Student Signature: \_\_\_\_\_

**Photography Release:** You have my permission to use my child's picture in the "My Week At Shady Creek" CD. This CD is a fund-raiser and will be available for purchase only to participating schools. Photo's will not be used for any other purpose.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**1. Waiver and Release of Claims.** Parents, for ourselves and on behalf of Student, hereby release and hold harmless Superintendent, its officers, officials, agents and/or employees, volunteers, other participants (collectively "Releasees"), for any and all injury, accident, disability, death, or loss or damage to person or property, whether arising out of or in any way related to voluntary participation in the Program, including the negligence or intentional act of the Releasees or otherwise. This waiver and release applies to the Program, travel to and from the Program, and any other events or circumstances related to participation in the Program. Parents voluntarily agree, for ourselves and for our heirs and representatives, that if any claim, cause of action, or proceeding for accident, illness, injury, death or any other claim shall be prosecuted, including but not limited to a claim for negligence against the Superintendent, or its employees, officers, board members, or agents, arising from my Student's participation in the Program, during or related to said participation, including, but not limited to a suit filed by Student or guardian ad litem on behalf of Student, we and our heirs and representatives will defend, indemnify and hold harmless, the District, and all of its employees, officers, board members and agents from any and all such claims and causes of action including attorney's fees, and further agree to be bound by the terms of this Waiver and Release set forth above.

I HAVE READ THE FOREGOING RELEASE OF LIABILITY AGREEMENT ENTITLED STUDENT WAIVER AND RELEASE, FULLY UNDERSTAND ITS TERMS AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

\_\_\_\_\_  
Parent

DATE: \_\_\_\_\_

## Instructions for Completing Medication Authorization Form

All prescription and over-the-counter medications are kept locked in the health center and will be administered only as authorized by the parent and child's physician. Only asthma inhalers may be kept in the child's cabin. No medication will be administered unless it is received in its original container, with this signed authorization form.

Steps to complete the Medication Authorization Form:

1. Determine if your child will need to bring prescription or non-prescription medicine to Shady Creek.
  - a. Do not send any of the following non-prescription medications because, with your signed permission, they are already available:

Advil (dysmenorrhea) (for fever or pain)	Tylenol (head/muscle aches)
Benadryl (localized itch/insect bite)	Kaopetate (diarrhea)
Caladryl Lotion (poison oak)	Actified/Sudafed (nasal congestion)
Mylanta (upset stomach)	Neosoprin Ointment (minor cuts/burns)
Cough Drops (cough)	Robitussin (cough)
Cortisone .5% Cream (itch/rash)	Dramamine (motion sickness)
Rid/Nix (lice treatment)	
2. Submit the Medication Authorization Form to your child's physician for completion. All medication, both prescription and non-prescription, not listed above requires a physician's signature and complete (legible) instructions from the physician. We cannot administer any medication (prescription or non-prescription) you send for your child without this signed form.
3. Verify that all medications are properly labeled and authorizations have been given. Verify that:
  - a. All medications are in original containers.
  - b. All medications are properly labeled, (use masking tape if necessary), including:
    - 1) student's name (prescription must be for the student only, no other name will be accepted)
    - 2) medication name
    - 3) precise dosage instructions, quantity and frequency (prescription only)
    - 4) physician's name (if prescription)
    - 5) school's initials: example "Tierra Buena" would be T.B.
    - 6) Spanish labels must be translated to English on the Authorization Form
  - c. The prescription medications are not expired.
  - d. All medications are listed on this signed Medication Authorization Form with proper instructions for administration.
4. Fold this form and place it in a zip-lock baggie with all the medications (both prescription and non-prescription in original containers) and forward the bag to your child's school to transport to Shady Creek.
  - a. Label the baggie with your child's name and school (use masking tape).
  - b. DO NOT send any medication to the site in your child's suitcase.
  - c. Vitamins should not be sent to the site unless ordered by a doctor.

If you have any questions regarding your child's medication or these instructions, please contact your child's school or Shady Creek Outdoor School.

Thank you for your cooperation and help. We appreciate you taking the time to complete this form. It is important information that will help make your child's experience safe and enjoyable!

(Please see other side)

**PLEASE COMPLETE FULLY AND CAREFULLY**

**Medication Authorization Form  
To be completed by child's Physician**

Student's Name: \_\_\_\_\_  
(Last) (First)

<b>Medication</b> _____ Purpose of Medication _____ Dosage Prescribed _____ Time Schedule _____ Dose Form (tablet, liq) _____	<b>Medication</b> _____ Purpose of Medication _____ Dosage Prescribed _____ Time Schedule _____ Dose Form (tablet, liq) _____
<b>Medication</b> _____ Purpose of Medication _____ Dosage Prescribed _____ Time Schedule _____ Dose Form (tablet, liq) _____	<b>Medication</b> _____ Purpose of Medication _____ Dosage Prescribed _____ Time Schedule _____ Dose Form (tablet, liq) _____

Precautions, special instructions, possible adverse effect(s), or comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above named child is under my care: Fax Number: \_\_\_\_\_

Physician's Name (print): Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_

Office Name and Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the school to administer the above listed medications in accordance with the instructions noted.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Technician's Use Only: _____ _____ _____
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