Sutter County SuperIntendent of Schools - Shady Creek Outdoor School Program

Adult Health Form

General Information

Name: _____ Date: _____

(First & Last) (Nature Name)

School: _____ Gender: _____

(Optional)

Address: _____

Street City Zip

Emergency Contact: _____ Phone: _____

What is your role this week? Circle One

Health Staff	Aid	Principal	Other:
Teacher	Cabin Leader	Resident Staff	_____

General Health

1. Do you know of any health factor that makes it advisable to limit your activity? ____ Yes ____ No

   If yes, explain:_____

   _____

2. Do you have allergies? _____ Yes _____ No

   To plants or animals? (i.e., bee sting) _____

   To medicines (i.e., penicillin) _____

   To food (i.e. gluten) _____

3. Please list any special diets not listed above: _____

4. Have you been exposed to any communicable diseases within the past 21 days?

   ____ Yes ____ No If yes, which one? _____

5. Are all of your immunizations up to date? _____ Yes _____ No

   -If 'No', Please specify which immunizations are not up to date. Need to know in the event of an outbreak.

_____

6. Will you be taking any medication while at Shady Creek? _____ Yes ____No

   * If yes, please write instructions (what medicine, for what problem, how often, Doctor's name, etc.) on the last page of this form.

Please complete back side

PERMISSION FOR EMERGENCY TREATMENT

If an emergency arises, it may become necessary to secure the assistance of a physician. Please sign the following statement, which permits emergency care. (If you cannot authorize emergency care, your application MUST be reviewed by the program director before attending the outdoor school.)

Yes, PERMISSION GRANTED. I hereby authorize the Shady Creek Outdoor School to provide to me medical or surgical care, including care rendered through the facilities of a physician or a hospital in any emergency that may arise while at the outdoor school.

Signature: _____ Date: _____

WAIVER AND RELEASE OF CLAIMS

Participant hereby releases 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. 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. 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.

Signature: _____ Date: _____

Medications

We do not allow any medications, prescription or over the counter, to be kept in the cabins with the students. All such products must be kept in the “Gauze Pad” or in your locked vehicle.

Medicine Packaging Instructions:

1. Be sure each medicine is packaged separately. **Do not** mix different types of pills in one bottle.
2. Take care to assure that the container is secure, in good repair, and is labeled for the person who will be taking the medication.

Please complete the form below for each substance you are bringing. Securely attach additional sheets if necessary. Please print legibly. This information is sent with first responders in the case of an emergency.

Medicine Name: _____ Doctor’s Name: _____ Doctor’s Phone:_____ Name of Pharmacy:_____ Date filled:_____ Instructions:_____ _____	Medicine Name: _____ Doctor’s Name: _____ Doctor’s Phone:_____ Name of Pharmacy:_____ Date filled:_____ Instructions:_____ _____
Medicine Name: _____ Doctor’s Name: _____ Doctor’s Phone:_____ Name of Pharmacy:_____ Date filled:_____ Instructions:_____ _____	Medicine Name: _____ Doctor’s Name: _____ Doctor’s Phone:_____ Name of Pharmacy:_____ Date filled:_____ Instructions:_____ _____