Group #:_____

COLOMA OUTDOOR DISCOVERY SCHOOL
Student Medical Information and Release Form

PLEASE PRINT IN INK: Attach additional sheets if necessary.

Student's Name:	Boy / Girl (*circle*)	Date of Birth:
School Name:	Teacher:	
Home Address:	City:	Zip:
Family Physician:	Physician Phone:	
Insurance Company: (	Insurance Co. Policy #:	
**Attaching a copy of your insurance card is recommended but not required.*		

EMERGENCY CONTACTS:

Parent/guardian:	Relation:	Phone 1:	Phone 2:
Parent/guardian:	Relation:	Phone 1:	Phone 2:

If a parent/guardian cannot be contacted in case of emergency, please contact:

Name:	Relation:	Phone 1:	Phone 2:
Name:	Relation:	Phone 1:	Phone 2:

CHILD RELEASE AUTHORIZATION: List everyone authorized to pick up child, including parents:

Name:	Relationship:	Phone:

SPECIAL NEEDS:	YES	NO	Frequency and/or severity	**SPECIAL NEEDS:**	YES	NO	Frequency and/or severity
Allergies				Head lice (recent)			
Asthma				Nose bleeds			
Bedwetting				Physical disability			
Behavioral and/or Cognitive				Seizures			
Under Dr. care or recent hospitalization				Sleepwalking			
Diabetes				Stomach aches			
English Language Learner				Vegetarian/Vegan			
Headaches				Visually impaired			
Heart Defect/Disease				Other:			
Hearing impaired				Other:			

Please explain any items checked above. Attach additional sheet if necessary.

_____

_____

If necessary, should first aid be given? Yes _____ No _____ Date of last Tetanus shot_____/_____/_____

★OVER★

PARENT/GUARDIAN RELEASE

(Student's Name) _____ has my permission to attend the Coloma Outdoor Discovery School (CODS) as a school sponsored event. I recognize that in accordance with the California Department of Education's Code of Regulations, designated trained personnel from my child's school will be administering any medications described in the Physician's Statement. The designated trained personnel may communicate with the physician with regard to this medication. For the best interest of my child, a copy of this Medical Information and Release Form will be provided to his/her assigned parent chaperone, and relevant information will be communicated to CODS staff on a need to know basis, ensuring strict confidentiality of any sensitive information.

(Student's Name) _____ is in good health, however, in case of a medical or surgical emergency, I hereby authorize the physician selected by CODS to secure all proper and required treatment for my child. I also understand that a classroom teacher my authorize consent to treat my child if I am not present nor can be contacted. All expenses for treating my child shall be paid for by a parent or guardian.

If it is deemed that my son/daughter must be removed from the school for illness or disciplinary reasons, I understand that it is my responsibility to arrange immediate transportation home for him/her.

★ Parent/Guardian Signature: _____ Date: _____

Please return to classroom teacher two weeks prior to trip.

PRESCRIPTION AND OVER-THE-COUNTER (OTC) MEDICATIONS:

Medications, including OTC medications, can only be administered by designated trained personnel from your child's school, provided that this form is signed by an authorized health care provider AND a parent or guardian. *Note:* If you have been selected to attend CODS as a Chaperone, and your child requires medication, a physician's signature *is not* needed if you will be administering your child's medication. OTC medications include, but are not limited to: vitamins, allergy remedies (Benadryl, etc.), antiseptic and/or topical ointments, cold remedies, insect bite remedies, aspirin, non-aspirin substitutes, and poison oak remedies—CODS does not stock OTC meds. Prescription and OTC medications must be packaged individually in pharmacy-prepared containers (with only the amount to be administered) and given directly to school personnel. Medication labels must include:

- Student's name
- Authorized health care provider
- Name of medication
- Dose of medication
- Method of administration
- Time of administration

PHYSICIAN'S STATEMENT OF REQUIRED MEDICATION:

_____ should be given the following medication as designated below:
Student's name

Please attach additional sheet(s) as necessary.

Prescription Medication:	Dosage:	Method of administration:	Time of administration:	Special instructions and/or precautions:
OTC Medication: list allergy remedies, antiseptic and/or topical ointments, cold remedies, insect bite remedies, aspirin, poison oak remedies, etc.				

☐ Please allow _____ to keep an inhaler with him/her at all times. He/she is competent to safely self-administer medication.

☐ Please allow _____ to keep an epi-pen with him/her at all times. He/she is competent to safely self-administer medication.

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Place office stamp here.