

Klamath Outdoor Science School Health/Medical and Permission Form

All students and adults participating in KOSS programs must fill out this form completely.
Return this form to your teacher or group leader. Please PRINT CLEARLY.

Participant Name: _____ Age: _____ Birth date: ___/___/___
Parent/Guardian: _____ Home Phone: _____
Street Address: _____ Work Phone: _____
City, State, Zip: _____ Cell Phone: _____
Home e-mail: _____ Work e-mail: _____
Emergency Contact: _____ Home Phone: _____
Relationship: _____ Work Phone: _____ Cell Phone: _____

Please check if participant is subject to the following and include an explanation:

- | | | | |
|-------------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blindness | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Severe bee sting allergy | <input type="checkbox"/> Deafness | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Other allergies | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Other (specify below) |

Explanation: _____

List all current medications, time(s) taken, and for what condition(s): _____

List any allergies to medications, the reaction, and the severity: _____

List any past medical conditions, injuries, or illnesses that might affect the program, including any restrictions of activity for medical reasons: _____

Describe any behavior problems that might be disruptive to group learning: _____

List any dietary restrictions or food allergies (including reaction and severity): _____

Date of last tetanus inoculation (**Must be within the last 10 years.**) _____

Do you authorize the group leader or camp manager to dispense over the counter drugs, such as Tylenol, Advil, or Benadryl if needed? YES NO

Provider Information

Doctor's name: _____ Phone: _____
Insurance company: _____ Policy Number: _____
Insurance Address: _____

My child has my permission to participate in all sessions and field trip activities. I am this child's parent or legal guardian. In consideration of my child's participation in the program, I hereby release, waive, and discharge KOSS, and all of its instructors, employees, officers, directors, agents, and volunteers from any and all liability to me, to my child, and to all my legal representatives, assigns, heirs, and next of kin for damage and injury to my child or to any person or property arising out of participation in the program, whether on KOSS premises or elsewhere. I hereby grant permission for KOSS to use photographs including my child for any of its publications, including website entries, without payment or any other consideration.

Adult participant or parent/guardian signature: _____ Date: _____