Marin County Outdoor School

Walker Creek Ranch

(415) 491-6602 • Fax: (415) 663- 8854 • www.walkercreekranch.org

Registration and Health Form

** REQUIRED FOR ALL PARTICIPANTS**

Please complete BOTH sides of this form legibly and in ink. Be sure to SIGN where indicated. Return to the participant's school. Please call if you have any questions and feel free to use additional paper if necessary to describe any remarkable medical or health condition. Thank you.

Participant is a: ☐ **Student** ☐ **Cabin Leader** ☐ **Adult Chaperone** ☐ **Teacher/School Staff**

PARTICIPANT INFORMATION

Name		Male / Female/ Other	Date of Birth	Age
School Strawberry Elementary	Teacher	Dates Attending		
Home Address (Street)	(City)	(Zip Code)	Home Phone ( )	
Parent /Guardian Name	Work Phone ( )		Cell Phone ( )	
Parent / Guardian Name	Work Phone ( )		Cell Phone ( )	
Email Address:				

EMERGENCY CONTACT INFORMATION: Person to call if parents / guardians are not available:

Name (Relationship)	Day Phone:	Evening Phone:

INSURANCE AND PHYSICIAN INFORMATION

Physician's Name / Location	Health Insurance Provider:
Physician's Phone Number:	Health Insurance Member Number:

Health Information necessary for student's protection and care:

Please check if participant has suffered from or been diagnosed with any of the following:

- ☐ Diabetes
- ☐ Epilepsy/Seizure Disorder
- ☐ Heart Condition
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Ear Infections
- ☐ Eye Trouble
- ☐ Glasses/ Contacts
- ☐ Hernia (Rupture)
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Any serious illness or accident
- ☐ Autism
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Sleep walking
- ☐ Bedwetting

Other (explain below)

Allergies:

- ☐ Hay Fever
- ☐ Bee Sting/ Insect
- ☐ Food (Describe in detail on Dietary Form)
- ☐ Medication
- ☐ Other _____
- ☐ Anaphylaxis to any of the above

Does your student carry an:

- ☐ Epi-pen
- ☐ Inhaler

Date of last Tetanus Shot:_____

Has participant been exposed to anyone with a communicable disease within the last 21 days? ☐ NO ☐YES

If YES, What disease?

Is the participant considered to generally be in good health?

Please explain any items checked above or any other medical conditions not listed (use additional sheets if necessary).

Are there any restrictions on the participant's physical activity? ☐ Yes ☐ No

If **YES,** please explain:

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ROUTINE MEDICATIONS

Will/might the participant take any prescription or non-prescription medications at Walker Creek Ranch?

☐ YES ☐ NO

Please note: ANY medication, prescription or non-prescription, requires the **Authorization to Administer Medication** form to be completed and signed by the participant's physician and parent/guardian.

DIETARY RESTRICTIONS

Does the participant have any dietary restrictions or food allergies? ☐ Yes ☐ No

If **YES,** please fill out the additional **Dietary Information** form

****REQUIRED FOR ALL PARTICPANTS****

I agree the above information is correct to the best of my knowledge. I approve of administering medications as stated above. Should the participant need to be removed from the Walker Creek Ranch Program because of illness or misconduct I agree to provide transportation home.

For minor illnesses or injuries, I understand that Walker Creek Ranch will attempt to contact me at the earliest practical opportunity. Should a medical emergency arise and I am not immediately available, I hereby authorize medication, medical and/or surgical care may be provided for the participant through the facilities of the nearest hospital.

Walker Creek Ranch promotional videos or photos may be taken and used for promotional purposes or put on our web site. If you do not wish to have your child included in such videos or photos, it is your responsibility to contact the outdoor school no later than two weeks prior to the outdoor school program. Walker Creek Ranch (415) 491-6602.

Signature of Parent / Guardian:

X **Date:**

Voluntary Additional Information

You are encouraged to voluntarily provide any additional information about the participant that will help us to understand how we can best support their success during their time at Walker Creek Ranch. This may include special concerns with respect to cabin assignments or other activities, anxieties about being away from home, showering, emotional concerns, sexual orientation, gender identity**,** or any other aspect of the participant that you believe may be helpful to Walker Creek Ranch staff. Please use this space, and additional space as necessary, to provide any additional information that you think may be helpful. Please note this information will be kept confidential and will only be shared with appropriate school staff working with the participant.

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Authorization to Administer Medication

This form authorizes administration of medication while the participant attends Walker Creek Ranch. District Policies of attending schools will be followed with regard to administering all medications. Visiting School Staff are responsible for ensuring that medications are administered daily.

Name	Male / Female	Date of Birth	Age
School STRAWBERRY ELEMENTARY	Teacher	Dates Attending	

Per California Education Code 49423, school districts may no longer administer medication without a doctor's recommendation. **For any medication, prescription or non-prescription, to be administered at Walker Creek Ranch, both sides of this form must be completed and signed by a physician** (or other health care provider who has the authority to prescribe medication). **Without both authorizations,** we will not be able to administer **any** medication to your child (except "Epi-Pen" epinephrine in the case of life threatening allergic reaction).

PRESCRIPTION AND REGULARLY TAKEN NON-PRESCRIPTION MEDICATIONS

Medication Name	***Condition being treated***	***Method of Administration and Time to be Given***	***Dosage Amount and Frequency***	***Comments: Special instructions, precautions, possible side-effects***	***Date to Discontinue***

(If more space is needed, attach a separate page with signatures)

PARTICIPANTS WITH ASTHMA OR SEVERE (ANAPHYLACTIC) ALLERGIES

Known Allergy: _____

What is to be given and when: _____

Please indicate if the participant has permission to carry their inhaler and/or epi-pen on their person and use as needed while attending the Marin County Outdoor School.

□ Yes – This participant has permission to carry their inhaler and/or epi-pen on their person.

□ No – This participant may not carry their inhaler and/or epi-pen on their person; it must be on the person of a responsible adult at all times.

DIRECTIONS FOR SENDING MEDICATION TO WALKER CREEK RANCH

ALL medication sent with the participant, must be in the original container and clearly labeled with the following information:

- **PARTICIPANT'S NAME,**
- **PHYSICIAN'S NAME,**
- **NAME OF MEDICATION,**
- **DOSAGE (how much and when)**

DO NOT pack medicines in the participant's luggage. Medication must be given to the Strawberry School office for delivery to Walker Creek Ranch

OVER-THE-COUNTER MEDICATIONS

If you wish to send any nonprescription medications to be administered on an as-needed basis while at the Outdoor School, please indicate below. These medications must be in the original containers labeled clearly with the participant's name.

Approved Medication Name (Generic versions may be used)	Dosage/Route if other than on package	Comments: Precautions, Side-Effects to watch for	Physician's Signature Indicating approval
Pain Relievers			
Cold Cough Medication			
Digestive Aids			
Topical Creams and Ointments			
Allergy Relief			
Other Approved Medications (If applicable)			

PHYSICIAN OR AUTHORIZED HEATHCARE PROVIDER

As the physician of the above named participant, it is, in my professional opinion appropriate and necessary that the above medications be available for administration during the student's overnight stay at Walker Creek Ranch. The information on this form is current and is in effect until: (Date) _____

Print Name of Physician: **Phone Number:**

Address: **License Number:**

Signature of Physician:

X **Date:**

PARENT OR GUARDIAN

I am the parent and/or legal guardian of the above participant. I hereby give consent that the medication(s), both prescription and nonprescription, indicated above be administered to the participant in accordance with my physician's instructions. I will notify Walker Creek Ranch immediately if I change physicians or if the medication is changed. I agree to hold the district, its officers, employees, or agents harmless from all liability, suits, claims, of whatever nature or kind, which may arise out of these arrangements.

Signature of Parent / Guardian:

X **Date:**

Return form to Strawberry Elementary School office or FAX to: (707) 526-0906

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Dietary Information

Please fill out this form if the participant has dietary considerations that need to be accommodated.
For further information about menus or specific food allergies or our ability to accommodate dietary restrictions, please contact our Food Services Manager (415) 491-6600.

If you need to send food items to supplement the participant's menu while they are at Walker Creek Ranch, please send food labeled with the participant's name to the Dining Hall Kitchen on arrival day.

Participant is a: ☐ **Student** ☐ **Cabin Leader** ☐ **Adult Chaperone** ☐ **Teacher/School Staff**

Name			Male / Female	Date of Birth	Age
School	Teacher		Dates Attending		
Dietary Preferences:	☐ Vegan	☐ Vegetarian	☐ NO Pork	☐ NO Red meat	☐ NO Fish

Allergies or Medical Restrictions. Student can NOT have:

☐ Eggs ☐ Dairy ☐ Gluten ☐ Nuts ☐ Other _____

Please provide specific details and use additional sheets as necessary:

What happens if the participant ingests these foods? (I.e. anaphylaxis, intolerance, rash, etc.)

Additional Comments: Please use this space to add any comments or concerns regarding dietary needs or restrictions.