

Sutter County Superintendent of Schools -- Shady Creek Outdoor School Program  
 Student Registration and Health Form



**TO BE COMPLETED BY PARENT OR GUARDIAN**

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Gender \_\_\_\_\_  
 (Last) (First) (Nickname)

Teacher's Name \_\_\_\_\_ School \_\_\_\_\_

Home Address (Street) \_\_\_\_\_ City/Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Cell Number: \_\_\_\_\_ Home: \_\_\_\_\_

Parent of Guardian \_\_\_\_\_ Cell Number: \_\_\_\_\_ Home: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Office Address \_\_\_\_\_ Phone: \_\_\_\_\_

**GENERAL HEALTH INFORMATION**

**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. \_\_\_\_\_

**Are your child's Vaccination Records on file with their school?:** Yes \_\_\_ No \_\_\_

\*If "No", please attach immunization records to this form.

**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	K. <b>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	Body part injured _____		Injury Date _____
Other .....	<input type="checkbox"/> yes	<input type="checkbox"/> no	(Describe all activity restrictions below)		
<b>B. Asthma</b> .....	<input type="checkbox"/> yes	<input type="checkbox"/> no	L. <b>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 below)		
<b>D. Bedwetting (currently)</b> .....	<input type="checkbox"/> yes	<input type="checkbox"/> no	M. Sinus Problems.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>E. Bowel Problems</b> .....	<input type="checkbox"/> yes	<input type="checkbox"/> no	N. Sleep Walking (history of).....	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>F. Epilepsy or seizure disorder</b> .....	<input type="checkbox"/> yes	<input type="checkbox"/> no	O. ADD or ADHD.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>G. Fainting</b> .....	<input type="checkbox"/> yes	<input type="checkbox"/> no	Bringing Medication?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>H Headache</b> .....	<input type="checkbox"/> yes	<input type="checkbox"/> no	P. Diabetic.....	<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):

\_\_\_\_\_

\_\_\_\_\_

**Authorization For Medical Treatment**

**SIGNATURE REQUIRED OR STUDENT CANNOT ATTEND OUTDOOR SCHOOL**

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 administer first aid to my child as needed and assist my child in the use of medications listed on the attached Medication Authorization Form.

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

\_\_\_\_\_  
Date

**Photography Release**

I understand that while participating in the Shady Creek Outdoor School program my child may be photographed and/or videoed for advertising, and professional and/or public relations purposes. I authorize Shady Creek Outdoor School and Sutter County Superintendent of Schools to post pictures, videos, and/or film likeness of my child for the use of advertising and professional and/or public relations in connection with the education program. This includes, but is not limited to, social media and website content.

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

\_\_\_\_\_  
Date

I do not authorize Photography Release of my child

**Discipline and Refund Policy**

Please be advised that all rules of the student’s school apply while at outdoor school. Parents or Guardians will be notified of disciplinary infractions whenever possible. If multiple infractions, or severe infractions occur, it may be possible that a student will be sent home early from outdoor school. Shady Creek does not issue reimbursements or credit schools for students who are sent home because of illness, disciplinary issues, or any other situation that may require your child to leave Shady Creek early.

**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.**

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

\_\_\_\_\_  
Date

**Information**

Shady Creek will collect student’s name, dietary restrictions, and other relevant information. I authorize the sharing of this information with other schools in attendance the same week as my child.

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

\_\_\_\_\_  
Date

**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. 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.

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

\_\_\_\_\_  
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.

Shady Creek does not provide over the counter medication.

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, school and teacher, (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**

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

School Name: \_\_\_\_\_ Teacher Name: \_\_\_\_\_

<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: _____
_____
_____