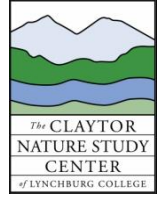


Claytor Nature Study Center Day Camp

Health History / Parent/ Guardian's Consent Agreement Form



INSTRUCTIONS: Please provide detailed health information for determining appropriate supervision, support, and accommodations during this Claytor Nature Study Center Day Camp. **A parent or guardian must sign. PLEASE PRINT ALL INFORMATION**

Claytor Nature Study Center does NOT administer over-the-counter or prescription medications to program participants except in life threatening or emergency situations. Please contact Education Coordinator Danielle Racke at 540-587-4061 with any questions or concerns that you may have.

Dates of Camp Session: _____

Participant Identification:

Name _____ T-Shirt Size _____
Last First M.I.
Mailing Address _____ Home Phone # _____
City _____ State _____ Zip _____
Age _____ Birth date _____ Home Email _____

Gender: Please circle one (Male/ Female)

Parent / Guardian Identification:

Father's Name (or Guardian) _____ Email _____
Daytime Phone # _____ Evening _____ Cell #: _____
Mother's Name (or Guardian) _____ Email _____
Daytime Phone # _____ Evening _____ Cell #: _____
Who has primary custody of the participant? _____
Address, if different than child _____

Physician/ Insurance Information:

Family Physician Name _____ Phone _____
Do you carry Family Medical/ Hospital Insurance? (Check One) Yes ___ No ___
Carrier _____ Policy ID# _____

Emergency Contact Information:

- Where can you be reached in the event of an emergency?
Location _____
Phone _____ Cell Phone _____
- If you CANNOT be reached, who should be notified?
Name _____
Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Participant Health and Medical History: *(Questions 1-5 must be completed)*

1. Special Dietary Needs

Instructions: The purpose of this section is to communicate special dietary needs, food allergies, etc. for any child who will be attending camp.

In the space below, please list all food allergies for the person listed above and any necessary precautions that should be taken:

In the space below, indicate any food restrictions (non-allergy) for the person listed above and food substitutes that may be considered:

2. Has the participant ever experienced (or had special needs in) any of the following?

{Check all that apply}

- | | |
|--|--|
| <input type="radio"/> Asthma | <input type="radio"/> Bleeding Disorders |
| <input type="radio"/> Eating Disorders | <input type="radio"/> Seizures/ Convulsions |
| <input type="radio"/> Diabetes | <input type="radio"/> Attention disorders (ADHD) |
| <input type="radio"/> Fainting Spells | <input type="radio"/> Other: _____ |
| <input type="radio"/> Wears Contacts | |

Please describe any condition or need that you checked:

3. Is the participant experiencing any current health problems, under medical care, receiving mental or behavioral services, or currently taking medication?

- Yes No If Yes, Please Explain: _____

4. Has the participant undergone surgery, or experienced any injury, illness, allergy, or change in health status any time during the last year? Is there any reason that participation in a program or activity should be restricted?

- Yes No If Yes, Please Explain: _____

5. What else should we know about your child?

Immunization History: Are your child's immunizations up to date?

- Yes
- No

Date of Most Recent Tetanus Shot: (Month/Year)

/

Release Authorization

I give permission to the following individual(s) to pick up my child:

Person (s) Authorized To Pick Up Child
Person (s) <u>NOT</u> Authorized to Pick Up Child*

Agreements

1. I give my permission for the participant named on this form to attend the Claytor Nature Day Camp. He / She has permission to participate in all activities which may include running, hiking, sampling macro invertebrates in the river, wading in ankle-deep water, using bug sweep nets, physical activity and exercise, and other related activities under the supervision of instructors; subject to limitations noted herein.
2. The Claytor Nature Study Center of Lynchburg College agrees to notify the parent(s)/ guardians (s) when the child becomes ill and the parent (s)/ guardian (s) will arrange to have the child picked up as soon as possible if so requested by the center.
3. The parent (s)/ guardian (s) authorize the Claytor Nature Study Center to obtain immediate medical care if any emergency occurs when the parent (s)/ guardian (s) cannot be located immediately. **
4. The parent (s)/ guardian (s) agree to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.
5. All information on this form is true and complete to the best of my knowledge.

Signatures

Parent (s) or Guardian (s) (PRINTED NAME)	SIGNATURE	DATE
Administrator of Center (PRINTED NAME)	SIGNATURE	DATE

** If there is an objection to seeking emergency medical care, a statement should be obtained from the parent (s)

that states the objection and the reason for the objection.