

OMSI PROGRAM HEALTH AND MEDICAL FORM

All students and adults participating in OMSI Science Camps programs must fill out this form completely. Return this form to your teacher/group leader as early as possible. *PLEASE PRINT CLEARLY IN BLUE OR BLACK INK.*

PARTICIPANT INFORMATION

Participant Name: _____ DOB and Age: _____
Parent/Guardian: _____ Home Phone: _____
Street Address: _____ Work Phone: _____
City, State, Zip: _____
Home Email: _____ Work Email: _____
Emergency Contact: _____ Home Phone: _____
Relationship: _____ Work Phone: _____

HEALTH AND MEDICAL HISTORY: Please check if participant is subject to the following and include explanation.

- | | | | | |
|--|--|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Bee Sting Allergy | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Deafness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dyslexia |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Other |

Explanation: _____

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

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

Do you authorize the group leader or Program Coordinator to dispense over the counter drugs, such as Tylenol, Advil or Benadryl if you are not reachable to give immediate permission? Yes No

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

Date of last tetanus inoculation. MUST BE WITHIN LAST 10 YEARS. (If your child was immunized before attending school, he or she received a tetanus shot at age 5.) _____

Describe any behavior problems or habits that would be disruptive to group learning: _____

List any food preferences or dietary restrictions (e.g. vegetarian, no pork, low salt, etc.): _____

List allergies to any foods, the reaction, the severity, and the amount tolerated (e.g. for lactose intolerance, can small portions of milk be used in cooking?): _____

PROVIDER INFORMATION

Doctor's Name: _____ Phone: _____
Insurance Company: _____ Agent Name: _____
Insurance Address: _____ Policy Number: _____
City, State, Zip: _____

My child has my permission to participate in all session and field trip activities. I am this child's parent or legal guardian, who is under the age of 18 years and who wants to participate in OMSI's programs. In consideration of my child's or ward's participations in the programs, I hereby release, waive, and discharge OMSI, and all of its instructors, employees, officers, directors, agents, and volunteers from any and all liability to me, to my child or ward, and to all my legal representatives, assigns, heirs, and next of kin for damage and injury to my child or ward or to any person or property arising out of participation in the program, whether on OMSI's premises or elsewhere. This agreement includes but is not limited to claims or demands on account of injury or damage caused or allegedly caused by the negligence of OMSI or any of the individuals listed above.

Adult participant or parent/guardian signature: _____ Date _____