

SARGENT CENTER

HEALTH INFORMATION AND CONSENT FORM FOR SCHOOL PROGRAM

(Page 1 and 2 to be completed by Parent/Guardian, Page 3 to be completed by physician. We suggest retaining a copy of this form for your files, as it cannot be released or used for any other program.)

Name _____ Date of Birth _____ Gender ____ Age _____ Ht. _____ Wt. _____

Custodial Parent's/Guardian's Name(s) _____

Mailing Address _____ City _____ State ____ Zip _____

School attending with: _____ Preferred e-mail address _____

1st Parent Name _____ Phone: H (____) _____ Bus. Phone (____) _____
Cell Phone (____) _____

2nd Parent Name _____ Phone: H (____) _____ Bus. Phone (____) _____
Cell Phone (____) _____

Please list any additional parent/guardian phone numbers on a separate piece of paper and attach to this form.

Emergency Contact (other than parent) _____ Home Phone (____) _____

Business Phone (____) _____ Cell Phone (____) _____ Relationship to Child _____

Child's Doctor _____ Phone (____) _____

Child's Dentist _____ Phone (____) _____

Child's Orthodontist _____ Phone (____) _____

Health Insurance Co. _____ Policy # _____

1. MEDICAL CONSENT: Must be signed by parent/guardian

I consent to and authorize emergency and non-emergency medical care to be provided to my child in the event of a health problem, emergency or injury occurring during my child's attendance at camp. I give my consent and authorization to the camp director or his/her designee to use his/her judgment in seeking medical care for my child. I understand that an attempt will be made to contact me in the event that medical care is needed, and that I am responsible for all medical costs incurred in treating my child* (See page 2 for information on Nature's Classroom supplemental insurance).

Signature of parent/guardian _____ Date _____

Optional: If you wish for religious or other reasons, you may indicate your refusal to consent to certain medical care (i.e., blood transfusions), as follows: Notwithstanding the above, I do not consent to the following diagnostic tests or medical treatment for my child: Specify

Signature of parent/guardian _____ Date _____

2. WAIVER AND RELEASE: Must be signed by parent/guardian

I wish to enroll my child in the Program/Activity referred to above at Sargent Center, Hancock, New Hampshire. I recognize that some of the activities at Sargent Center involve physical risk, including the risk of serious injury. I hereby agree, on behalf of my child and myself, to assume all of the risks in connection with my child's attendance, including travel, except in the case of gross negligence or willful misconduct. I understand that in the event of an illness or behavioral problem, I may be required to pick up my child. The term Nature's Classroom shall include the corporation and its successors, trustees, officers, agents, representatives, contractors and all persons for whose conduct Nature's Classroom is or could be legally responsible. I agree that the laws of the Commonwealth of Massachusetts shall govern this waiver and release. I affirm that I have read and understood this document.

Signature of parent/guardian _____ Date _____

PROMOTIONAL RELEASE: Must be signed by parent/guardian

I authorize Nature's Classroom to reasonable use of any and all images and statements of/by/about the camper during any part of the Sargent Center experience for promotional purposes.

Signature of parent/guardian _____ Date _____

3. IMPORTANT HEALTH INFORMATION: (To be completed by parent or guardian). To make your child's stay at Sargent Center as safe and pleasant as possible, please complete in full.

1. Allergies: Food, drug, or other allergies (insect bites, pollen)? ____ If yes, what? _____
Type of reaction: _____

2. Any existing medical or behavioral conditions (physical, mental or emotional)? _____

3. Is there any factor that makes it advisable for your child to limit program of physical activity, i.e. heart condition, recent fracture, surgery, asthma or fears? _____ If yes, describe? _____

4. Is your family experiencing any stressful situation (such as divorce, serious illness, or death) that might be a concern to your child at this time? _____

5. Dietary needs? (including vegetarian and lactose intolerant) _____

If yes, call the nurse at least one week prior to attendance to discuss special needs (603-525-3311, ext 19).

6. In order to protect your child from possible embarrassment, what would you like Sargent Center staff to know? _____

7. Does your child wet the bed? _____ Walk in his/her sleep? _____

8. Is your child prone to homesickness? ____ If yes, what are the indicators? _____

4. PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS THROUGH HEALTH CENTER.

Listed below are medications available at Sargent Center for occasional use as needed. Please check those medications your child may receive and sign on parent/guardian line.

For headache/minor pain:

___ Tylenol (acetaminophen)

___ Advil (ibuprofen)

For stomach/bowel upset

___ Tums

___ Maalox

___ Pepto Bismol

___ Milk of Magnesia

For cold/allergy symptoms:

___ Sudafed

___ Benedryl (diphenhydramine)

___ Claritin (loratadine)

___ Robitussin cough syrup

___ Throat Lozenges

For Poison Ivy:

___ Zanol

___ Buji Wash

___ Calamine or Calagel Lotion

Other topical products:

___ Insect Repellent

___ Sunscreen

___ Hydrocortisone Ointment

___ Benadryl Anti-itch Gel

___ Aloe Vera

Does your child swallow pills? ____

I authorize the camp nurse or designee to assess the need for and appropriately administer the above checked medications.

Parent/Guardian Signature _____ **Date** _____

5. IF YOUR CHILD IS BRINGING NON-PRESCRIPTION (over the counter) MEDICATION TO CAMP, PLEASE COMPLETE AND SIGN THIS SECTION. MEDICATIONS MUST BE IN ORIGINAL CONTAINERS. SARGENT CENTER IS FORBIDDEN BY STATE LICENSING LAW TO DISPENSE MEDICATIONS THAT ARE NOT IN THEIR ORIGINAL CONTAINERS.

Medication Name: _____ Reason for administration _____

Complete directions for administration _____

Medication Name: _____ Reason for administration _____

Complete directions for administration _____

The above information and directions for administration of all medications is complete and correct. I authorize the camp nurse or his/her designee to use his/her discretion in giving the above medications as indicated.

Parent/Guardian Signature _____ **Date** _____

SUPPLEMENTAL INSURANCE: For each participant: Nature's Classroom is providing an accidental death benefit of \$50,000. In addition, we are providing an accidental medical expense benefit of \$10,000 which is over and above your insurance coverage.

Pre-existing conditions are not covered. Sickness benefits are not covered-this is an accident only benefit. page 2

**SARGENT CENTER
HEALTH MEMORANDUM**

(This form or its equivalent must be completed by a physician or nurse practitioner)

New Hampshire State law recommends any child attending camp will have had a physical examination within **two** years of attending camp. **Physician's orders for prescription drugs to be taken at camp must be written within the current year.**

Name of Child _____ was examined on the following date _____.

In addition, the health history and immunization records have been reviewed.

Any existing medical condition (chronic or recurring illnesses?) _____

Health History (Please check all that apply)

_____ Allergies:

_____ Drug (specify) _____	_____ Type of reaction _____
_____ Food (specify) _____	_____ Type of reaction _____
_____ Environmental (specify) _____	_____ Type of reaction _____

_____ Asthma (Type) _____ Well controlled? _____

_____ ADD or ADHD _____ Well controlled? _____

_____ Mood or mental health disorder _____ Well controlled? _____

_____ Diabetes (age of onset) _____ Well controlled? _____

_____ Heart Condition (specify) _____ Any limitations? _____

_____ Seizure Disorder (type) _____ Well controlled? _____

Are there any factors which would preclude this child from participating fully, including a high ropes course, in the Sargent Center program? () Yes () No Specify activities to be limited: _____

EXCEPTION, COMMENTS, CONCERNS SPECIAL PROBLEMS, ETC.

Date of most recent exam _____ Last Tetanus Toxoid Immunization _____

Immunizations: _____ copy attached or _____ verified up-to-date.

Physician's Signature _____ **MD Phone** (_____)

Print/Stamp Name

PHYSICIAN ORDERS FOR PRESCRIPTION MEDICATION

(Must be completed and signed by physician in order for Sargent Center to give medications)

MEDICATIONS MUST BE IN ORIGINAL CONTAINER. THE DIRECTIONS ON THE CONTAINER MUST MATCH THE PHYSICIAN'S WRITTEN ORDERS. A WRITTEN ORDER SIGNED BY THE PHYSICIAN MUST BE RECEIVED TO AUTHORIZE ANY CHANGE IN DIRECTIONS.

Is this child on any prescription medications? () Yes () No

1. Medication and dosage _____ Times of administration _____

Reason to administer _____

2. Medication and dosage _____ Times of administration _____

Reason to administer _____

3. Medication and dosage _____ Times of administration _____

Reason to administer _____

Physician's Signature _____ **MD Phone** (_____)