NATURE'S CLASSROOM STUDENT REGISTRATION

Please print all information and please fill in all the blanks

Child's Name____ Date of Birth ______________________________
(Last) (First)

Age ______________________ Sex ______________________ Weight ____________ Height ____________________

Address____
(No. and Street) (Town) (State) (Zip)

Parent's Name(s)____

Email Address ____

Home Telephone (____) ____________________ Alternate Telephone (____) ____________________________________

Family Physician __________________________ Telephone (____) ____

I give permission for (Name) ____to attend Nature's Classroom

for the period of ____as part of the outdoor education program

of (School Name) ____ . I understand that the director of Nature's Classroom may, if necessary, for my child's health, have him/her hospitalized or use outside medical, surgical, or dental care. I also understand that the director and/or school leaders may dismiss my child from Nature's Classroom if, in their opinions, his/her conduct or influence is not in the best interest of the entire group. No refund is given if such action is taken for discipline reasons. Nature's Classroom has my permission to use my child's image, voice and/or likeness for promotional purposes.

Date _______________ Signature _____________________________________ Relationship____________________

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MEDICAL PERMISSION SLIP

Should your child become ill, get a headache, catch a cold or have other minor medical or dental problems, do you give permission for the administration of basic first aid at the discretions of the Nature's Classroom staff?

Yes_____ No_____

Date _______________Signature ________________________________ Relationship_____________________________

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If Ibuprofen or Tylenol needs to be administered, do you prefer:

IBUPROFEN_______ TYLENOL_______ OTHER (Specify) ____

Nature's Classroom

HOME AND HEALTH INFORMATION QUESTIONNAIRE

Child's Name:______________________________ Date of Session: ______________

The questions below are provided to give you a framework within which to provide that needed information to us. Please feel free to add whatever information you think will be helpful – attach additional sheets if necessary. We will share this information with your child's classroom teachers prior to his/her arrival at camp. Thank you for your cooperation.

1. Is this your child's first prolonged stay away from home? ______________________________
2. Is this your child's first sleep away experience? ______________________________
3. Has your child ever had a problem with homesickness? If yes, please explain briefly.______________________________

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____

4. Does your child have a bed wetting problem? ______________________________
5. Date of last tetanus booster shot (not a tetanus shot given after an injury). ______________________________
6. Are there any restrictions on your child's activities? Please include any special health concerns, e.g., special diet, recent hospitalizations, fractured bones, etc.

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____

____

7. List any allergies, e.g., food, environmental, medication, and explain degrees of severity and current treatment.

____

____

____

8. Does your child have any sensory, physical or cognitive disabilities? ☐ Yes ☐ No If yes, explain.

____

____

____

9. Has anything happened recently in your child's life that may affect him/her emotionally or physically while at camp? If yes, please explain.

____

____

____

10. Additional information:

____

____

____

____

Nature's Classroom

MEDICATION ADMINISTRATION FORM

<u>All medications</u> (including prescription, non-prescription and vitamins) <u>must come in original containers.</u>

Please complete *all parts* of the following chart for all medications being sent or the medication cannot be administered. If more than four medications are needed, please copy this page.

CHILD'S NAME: ______________________________

I hereby give permission for the staff of Nature's Classroom to administer to my child the following medication(s):

Medication	Dose (mg, tsp)	Time Medication Taken				
		Breakfast	Lunch	Dinner	Bed	Other

Comments (reason for taking medications, special considerations): ______________________________

____

____

____

Your child will not be allowed to keep any medication in his/her cabin. Prescribed medications must be in original container with pharmacy label containing Rx number, the name of the medication, the dosage, directions for administration, and the child's name. Whenever possible, a copy of the doctor's prescription or letter may be sent to clarify any discrepancies. All non-prescription medication must be in their original containers, clearly labeled with the child's name, name of the medication and direction for use.

Signed: ______________________________ Dated: ______________

Relationship: ______________________________

HARRINGTON MEMORIAL HOSPITAL
SOUTHBRIDGE, MASSACHUSETTS

GENERAL MEDICAL CONSENT FOR TREATMENT OF MINORS IN THE EMERGENCY ROOM

In case of accident or illness, I/we hereby authorize the physician and personnel at Harrington Memorial Hospital to examine and administer such treatment, medication and procedure(s) found to be necessary for the diagnosis and treatment of my/our son/daughter.

Name: ______________________________ Date of Birth: ________________

Exceptions: (If none, so state): ____

Date(s) this consent is in effect: ________________ through: ________________

The explanation of the medical problem will be made to the patient and/or the person who accompanies my/our offspring to the hospital. One or both of them shall sign the informed consent.

PARENT OR GUARDIAN MUST SIGN HERE:

Date: ____________ Signed: ______________________________________
(Relationship)

Date: ____________ Signed: ______________________________________
(Relationship)

Witness: ____

Patient's family physician: ______________________________________

Allergies: ____

Date of last tetanus immunization: ________________________________

Pertinent medical conditions: ____________________________________

Medications presently being taken: ________________________________

____

Medical insurance/person responsible for payment: ____________________

____

Policy #: ____

A photostat copy of this form is to be attached to each emergency record. This consent is to be kept in the permanent file if used. It is only valid for a **one month** interval.