MOUNT HERMON MINOR HEALTH FORM

Outdoor Science School
P.O. BOX 413
MOUNT HERMON, CA
95041

Dates attending OSS: from _____ to _____
Month/Day/Year *Month/Day/Year*

Student Name: _____
First *Middle* *Last*

☐ Male ☐ Female Birth Date _____ Age at OSS _____
Month/Day/Year

School _____

To Parent(s)/Guardian(s): Please complete all pages and sections of this form and *make a copy*! GIVE the original, signed FORMS to the school teacher. *Please keep the copy for your records.*

Student Home Address _____
Street Address *City* *State* *Zip*

Parent/Guardian with legal custody to be contacted in case of illness or injury

Name: _____ Relationship to Student: _____ Preferred Phones: (____)_____ (____)_____

Email: _____ Home Address: _____
(If different from above) Street Address *City* *State* *Zip*

Second Parent/Guardian or other emergency contact

Name: _____ Relationship to Student: _____ Preferred Phones: (____)_____ (____)_____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached

Name: _____ Relationship to Student: _____ Preferred Phones: (____)_____ (____)_____

Email: _____

MEDICAL INSURANCE INFORMATION

This student is covered by family medical/hospital insurance: ☐ Yes ☐ No

Include a copy of your insurance card; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber _____ Insurance Company Phone Number (____)_____

If no Health Care Plan exists, please read and sign below.

If you do not have your own Health Care Plan, we can provide insurance to your student while at camp. We are insured through Hartford Life and Accident Insurance Company. By signing below you authorize payment of any medical fees to physician or supplier for services described on any attached statements to be disclosed to Hartford Life and Accident Insurance Company for the fees to be paid. My consent is hereby granted to use this original or a photo static copy as equally valid authorization.

Signature of Custodial Parent/Guardian _____ Date _____ Relationship to Student _____

HEALTH-CARE PROVIDERS

Name of student's primary doctor(s): _____ Phone: (____)_____

Name of dentist(s): _____ Phone: (____)_____

Name of orthodontist(s): _____ Phone: (____)_____

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE

This health history is correct and accurately reflects the health status of the student to whom it pertains. The person described has permission to participate in all Mount Hermon Outdoor Science School activities except as noted by me and/or and examining physician. I give permission to the physician selected by Mount Hermon Association to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with OSS staff. I give permission to photocopy this form. In addition, Mount Hermon Association has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. I am aware that, at the discretion of the Science School Director, I will need to pick up my child due to medical or disciplinary reasons. I agree to be responsible for picking up my child. Mount Hermon Outdoor Science School policy is that in the event that a child needs to be sent home for any reason, no amount of the paid fees will be refunded if my child has attended the Outdoor Science School program for 24 hours or more.

Signature of Custodial
Parent/Guardian _____ **Date:** _____ **Relationship to Student** _____

MOUNT HERMON MINOR HEALTH FORM

Student Name: _____
First *Middle* *Last*

DIET, NUTRITION ☐ This student eats a regular diet ☐ This student eats a regular vegetarian diet
☐ This student has special food needs **(Please describe below)**

Note: Our kitchen will do its best to provide for special food needs. However, if your child has extensive dietary needs, please contact your teacher and research the menu, you may need to send additional food to camp with your child.

RESTRICTIONS **Does the student have permission to go swimming while at Outdoor Science School?** Yes ☐ No ☐
☐ I have reviewed the program and activities of OSS and feel the student can participate without restrictions.
☐ I have reviewed the program and activities of OSS and feel the student can participate with the following restrictions or adaptations. **(Please describe below)**

ALLERGIES ☐ No known allergies. ☐ This student is allergic to: ☐ Food ☐ Medicine ☐ Other
☐ The environment (insect stings, hay fever, etc.)
(Please describe below what the student is allergic to and the reaction seen)

MEDICATION ☐ This student will not take any daily medications while attending Outdoor Science School.
☐ This student will take the following daily medication(s) while at Outdoor Science School:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Bring enough of each medication to last their entire stay. By law, all Prescriptions and Over The Counter medication must arrive in the original and appropriately labeled pharmacy containers, inside a Ziploc bag clearly stating students name and school. ALL medications will be turned in to the Health Center upon arrival from the teacher. DO NOT put any medication in the child's luggage, as the child will miss part of the orientation when they have to retrieve it. ALL medication should be turned in to the teacher before departure to camp. The Health Center staff will store and distribute medications as directed. Please contact your child's teacher for further information regarding the Health Center.**

Name of Medication	Date Started	Reason for Taking it	When it is Given	Amount or Dose Given	How it is Given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other: _____		

The following non-prescription medications are representative of what may be stocked in the Health Center and are used on an **AS NEEDED BASIS** to manage illness and injury.
Cross out those the student should NOT be given

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Pseudoephedrine (Sudafed)
Diphenhydramine (Benadryl)
Technu Extreme (Poison Oak skin wash)
Guaifenesin DM (Cough Medicine)
Docusate Sodium (Stool softener)
Medicane Swab (Sting Relief)
Triple Antibiotic Ointment
Hydrocortisone Cream
Tums
Aloe Vera Lotion
Cough Drops

MOUNT HERMON MINOR HEALTH FORM

Student Name: _____
First *Middle* *Last*

IMMUNIZATION HISTORY Provide month and year for each immunization. If the student has not received the below immunization's please initial _____

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dt) or (TdaP)						

GENERAL HEALTH HISTORY

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the student:

1. Ever been hospitalized? ☐ Yes ☐ No
2. Had fainting or dizziness? ☐ Yes ☐ No
3. Ever had surgery? ☐ Yes ☐ No
4. Passed out/had chest pain during exercise? ☐ Yes ☐ No
5. Have recurrent/chronic illnesses? ☐ Yes ☐ No
6. Had mononucleosis (mono) during the past 12 months? ☐ Yes ☐ No
7. Had a recent infectious disease? ☐ Yes ☐ No
8. If female, have problems with periods/menstruation? ☐ Yes ☐ No
9. Had a recent injury? ☐ Yes ☐ No
10. Have problems falling asleep/sleepwalking? ☐ Yes ☐ No
11. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
12. Ever had back or joint problems? ☐ Yes ☐ No
13. Have diabetes? ☐ Yes ☐ No
14. Have a history of bedwetting? ☐ Yes ☐ No
15. Had seizures? ☐ Yes ☐ No
16. Have problems with diarrhea/constipation? ☐ Yes ☐ No
17. Had headaches? ☐ Yes ☐ No
18. Have any skin problems? ☐ Yes ☐ No
19. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months? ☐ Yes ☐ No

- The student will carry an inhaler while at Outdoor Science School ☐ Yes ☐ No
- The student will carry an Epi-Pen while at Outdoor Science School ☐ Yes ☐ No

NOTE: If the student carries an epi-pen, please send one epinephrine kit with the student. It will be returned.

Please explain "Yes" answers in the space below, noting the number of the questions and if the student is currently under treatment for that specific item. For travel outside the country, please name countries visited and dates of travel.

MENTAL, EMOTIONAL, AND SOCIAL HEALTH: Check "Yes" or "No" for each statement

Has the student:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the student's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

WHAT HAVE WE FORGOTTEN TO ASK?

Please provide in the space below any additional information about the student's health that you think important or that may affect the student's ability to fully participate in the Outdoor Science School program. **Attach additional information if needed.**