



## Arrowhead Ranch Outdoor Science School CONSENT FORM

**All students must return this form filled out completely - this document DOES NOT give permission or consent for dispensation of prescribed or OTC medicines.**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_ City / State / Zip \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_

Parent / Guardian Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

### **EMERGENCY CONTACT (Other then named above)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### **INFORMATION ABOUT YOUR CHILD**

To protect your child from possible embarrassment, but not to exclude him/her from the program, the following information is needed. Please circle yes or no. If answer is yes please give more detail on the line provided. If more space is required please add a separate paper to consent form.

Does your child walk in his/her sleep, wet the bed at night, etc? Yes / No

If yes please explain: \_\_\_\_\_

Are there any factors, which might affect the health of your child; such as asthma, allergies, etc? Yes / No

If yes please explain: \_\_\_\_\_

Has your child been exposed to any communicable diseases (Measles, Mumps, Chicken Pox, etc.) within the past 21 days? Yes / No

If yes, which ones? \_\_\_\_\_

Has your child had a tetanus shot within the last 5 years? Yes / No Date: \_\_\_\_\_

Does your child have any allergies that can cause an allergic reaction from medications, foods, or environmental factors? Yes / No

If yes please explain type of reaction: \_\_\_\_\_

Does your child have any health factor(s) that would make it advisable for your child to follow a limited program of physical activity? Yes / No

If yes please explain: \_\_\_\_\_

**\*\*BOTH SIDES OF THIS FORM MUST BE COMPLETED\*\***

