DEEP PORTAGE HEALTH AND PERMISSION FORM

Student Name _____ Date of Birth _____ Age _____

Parent or Guardian Name _____

Home Phone _____ Work Phone _____

Home Address _____

City _____ State _____ Zip _____

Name of Health Insurance _____ Policy Number _____

Physician _____

Clinic Name _____ Clinic Phone _____

Current Health Information: *please answer all questions that apply to the above student.*

☐ **Asthma:** List triggers _____ Treatment currently used? _____

☐ **Diabetes:** please use the back of this form to describe insulin, snacks, and when to call you.

☐ **Special dietary regimen or food allergies:** please describe _____

☐ **Other allergies:** list _____ Does child carry epinephrine? _____

☐ **Bleeding disorder:** please describe _____ What is the treatment? _____

☐ **Seizures:** list all medications and when used _____

☐ **Muscle-Bone-Joint condition:** list _____ What is the treatment _____

☐ **Activity restrictions:** describe _____

☐ **Heart condition:** describe _____

☐ **Sleep problems:** ☐ bedwetting ☐ sleep-walking ☐ other _____

☐ **Other:** describe _____

☐ **Date of last tetanus booster** _____

Current Medications:

Please list all prescription medication your child will be taking while at Deep Portage.
Include inhalers, nebulizer, ritalin, etc. Use back of form in needed.
All prescription medication must be in a current pharmacy labeled bottle.

☐ **Medication #1:** Name of medication _____

Reason given _____

Amount given _____ Time given _____

Name of physician prescribing medication _____ Phone _____

☐ **Medication #2:** Name of medication _____

Reason given _____

Amount given _____ Time given _____

Name of physician prescribing medication _____ Phone _____

☐ **Will take an over-the-counter medication at Deep Portage**

Name of medication: (Include Tylenol, Ibuprofen, Sudafed) _____

Reason given _____

Amount given _____ Time given _____

All medication must be sent from home in the original over-the-counter container
No aspirin will be given. Child will receive only the recommended dose.

Please turn the form over and continue…

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Permission and Emergency Authorization for the Above Named Student:

1) The student has my permission to participate in Deep Portage.
2) Staff has my permission to give my child the above medications.
3) Deep Portage staff has permission to transport the student for educational and/or emergency reasons
4) Permission is granted, in a medical emergency, to the physician selected by the student's teacher or Deep Portage Staff to hospitalize, secure treatment for, and/or order injection, anesthesia, or surgery for student. I understand every effort will be made to reach me at the phone numbers listed above or if I can't be reached call:

   Name: _____ Phone: _____

   Directions to the contrary or additional health information must be attached to this form.
5) I believe all precautions will be taken for student care and supervision. I will not hold Deep Portage Staff, teachers, or chaperones responsible.

Signature of Parent or Guardian _____ Date _____

SPACE FOR ADDITIONAL INFORMATION: