

EXPLORING NEW HORIZONS OUTDOOR SCHOOL  
**COUNSELOR MEDICAL AUTHORIZATION AND MEDICAL HISTORY**

Counselor Name \_\_\_\_\_ School \_\_\_\_\_

Grade \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Street City Zip Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**If parents cannot be reached in case of emergency, please contact:**

Name \_\_\_\_\_ Day Phone ( ) \_\_\_\_\_ Evening Phone ( ) \_\_\_\_\_

The following information is required to ensure that your child's individual needs are met while attending outdoor school. This information is confidential and will be made available only to those people who are directly responsible for your child's well-being. In the event of an emergency, every effort will be made to contact the parents or designated individual. For the child's safety and well-being, **no** counselor will be allowed to attend without a completed and **signed** Consent Medical Authorization (see below).

Family Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Please check and fill out any information that the outdoor school staff should be aware of concerning your child.**

- Asthma
- Diabetes
- Headaches
- Convulsions
- Hypoglycemia
- Hyperactivity
- Allergies**
  - Pollen/ grasses
  - Dust/ mold
  - Insect bite
  - Foods
- ADD/ ADHD
- Bedwetting
- Sleepwalking
- Sleptalking
- Recent injuries
- Other \_\_\_\_\_

Please explain any medical or behavioral or emotional condition/ reaction or other problem(s), including the boxes checked: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List **ALL** medications your child will bring and instructions for administering. Please send medication in **ORIGINAL** containers: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any dietary restrictions or allergies and the reactions your child has (i.e. food allergies, lactose intolerance, vegetarian, etc) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The ENH staff has my permission to administer:	Cold medicines	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Date of last tetanus shot
	Tylenol	<input type="checkbox"/> YES	<input type="checkbox"/> NO	____ / ____ / ____
	Benadryl	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Tums	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

The Exploring New Horizons Staff has my permission to use a photographic image of my child for educational and promotional purposes only. I understand that no information will be revealed about my child, including their name, city and school.  YES  NO

Please include my child/myself on your mailing list for newsletters, summer camp announcements and other events  YES  NO

(Counselor's Name) \_\_\_\_\_ has my permission to attend Exploring New Horizons Outdoor School in conjunction with their regular school program. My child is in good health and I accept all financial responsibility for my child's attendance. **IN CASE OF MEDICAL EMERGENCY**, I hereby authorize the physician selected by the outdoor school to secure all proper and required treatment for the counselor listed. All expenses not covered by Exploring New Horizons' Accident Insurance Policy shall be paid by the parent or guardian (pre-existing conditions are not covered, e.g. asthma).

I am granting permission for my child to attend Exploring New Horizons Outdoor School. I agree that if my child is removed from the outdoor school for disciplinary reasons it is my responsibility to arrange transportation home.

\_\_\_\_\_  
**Signature of Parent/ Guardian** \_\_\_\_\_  
**Date**

**NOTE:** If your child requires specialized care or diet, please contact us as soon as possible so that we can make arrangements.