

We the parents of _____ would like to register our child for the experience in
(Please Print Child's Name)

Outdoor Education from ____ / ____ / ____ to ____ / ____ / ____ . Child's age ____ Girl Boy

Child's address _____ City _____ Zip _____

School and District _____

CONSENT TO TREATMENT OF MINOR AND RELEASE OF LIABILITY:

The undersigned hereby appoint Mohican School in the Out-of-Doors, Inc. and each of its authorized agents, each to act alone, and delegate to the same the power to consent on our behalf to all emergency treatment and/or any medical care (except elective surgery) of (child) _____, determined to be necessary or desirable by our child's attending physician at the hospital in which emergency treatment and/or medical care is sought.

This consent to treatment shall be in effect for the days my child attends Mohican School.

We, the undersigned, release Mohican School in the Out-of-Doors, Inc., its Board of Directors, officials and employees and any of its authorized agents, from any obligation or liability, actual or implied, concerning their use of this authorized consent to treatment.

The undersigned certify that they have read this consent to treatment and release of liability (or had it read to them), and that they understand the same. "This information will be summarized and provided to the Mohican School Staff who are in direct care of your child."

The medical information I have given about the child registered on this form is correct to the best of my knowledge.

*I have read or had read to me the information in the registration form and understand **my signature** is necessary to register my child. In the event the above child needs to go home before the outdoor session is complete, **the parent or guardian who signs this form must be the person who checks the child out at Mohican School unless the legal parent or guardian sends a signed note authorizing another person to do so.** The person who removes the child from Mohican School must identify him/her self and show a photo ID.*

PLEASE COMPLETE

Student's Full Name _____

Parent / Legal Guardian Information

(____) (____) _____
Day Telephone Numbers Night

Work Telephone (____) _____

Address _____

City _____ Zip _____

PARENT/LEGAL GUARDIAN SIGNATURE REQUIRED FOR PARTICIPATION IN MOHICAN SCHOOL PROGRAM!

Parent/Legal Guardian Signature _____

Date of Signature _____

*Your student's photo might be used by Mohican School in the Out-of-Doors, Inc. for advertising, brochures, or the Mohican Outdoor School slide presentation, but **no** identifying information will be included.*

*If you **DO NOT** wish the photo to be used in these ways, **please check the box AND sign below.***

*I **DO NOT** give permission to use a photo as stated above. Parent's signature _____*

This page must be filled out completely!

Student's Name _____

Please Note: If student needs medical attention while attending Mohican School, this form will be used by the hospital and/or the physician.

Mohican School insurance carrier: Hartford Insurance Company / Dawson Insurance, Inc., Mansfield, Ohio. \$100.00 deductible coverage, policy #33-CH-161288. \$5,000 limits of the policy.

In case of accident or sickness, I give my consent for a physician chosen by the Mohican School staff to treat my child as he or she deems necessary. I assume that every reasonable effort will be made to reach me in case of serious illness or accident. It is best if the student's family medical coverage is used but the Mohican School coverage is available if needed or desired.

If my child does require hospital or physicians' care (check one - choice):

I will use Mohican School's insurance and pay the deductible portion of the cost. Send the bill to me

Name _____ Address _____

I will **not** use Mohican School's insurance. Please use my present health insurance company.

Certificate # _____ Group # _____

Subscriber's Name _____ Employer's Name _____

Code # _____ Other Insurance Name _____

Policy # _____ Group # _____

**** Parents/guardians will be called if there is any other advice needed for care not specifically mentioned above.**

Check if your child has problems with the following:

- Bed Wetting
 - Asthma
 - Serious Insect Stings
 - Convulsions/Seizures
 - Penicillin
 - Sleep Walking
 - Hay Fever
 - Serious Poison Ivy
 - Diabetes
 - Other _____
- [complete separate Diabetes form available on website]

If your child needs the following but did not bring from home, the school has in pill form; no liquids available.

Please answer YES or NO for each question.

Does your child have permission to take acetaminophen for a headache &/or sore throat? **Yes** _____ **No** _____

Does your child have permission to take acetaminophen for an abnormal temperature? **Yes** _____ **No** _____

Does your daughter have permission to take acetaminophen for menstrual cramps? **N/A** _____ **Yes** _____ **No** _____

Does your child have permission to take cough drops for a sore throat or cough? **Yes** _____ **No** _____

Does your child have permission to receive topical antibiotic ointment/cream for treatment of skin abrasions? **Yes** _____ **No** _____

Date of child's last tetanus shot? ____/____/____ Has your child been under a physician's care recently? **Yes** _____ **No** _____

If yes, explain: _____

Please list anything about your child's health which would pertain to his or her welfare or activity while at the outdoor school not mentioned anywhere else, **including dietary needs:**

Physician's Name and Telephone Number _____ (____) _____

Dentist's Name and Telephone Number _____ (____) _____

Please write below as many **DIFFERENT TELEPHONE NUMBERS** as possible where you or a friend or a relative can be reached in the event of any emergency, if there is no answer at the first number.

NAME	DAY PHONES	NIGHT PHONES	RELATIONSHIP TO CHILD
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REQUEST FOR ASSISTANCE IN THE ADMINISTRATION OF MEDICATION
(Ohio Revised Code 3313.713)

Part I (completed by a parent or guardian).

I/we hereby request and give permission to designated personnel to help in the self-administration of medication to my child. **I am sending the medicine in the original container obtained from our physician or pharmacist.**

I/we understand and acknowledge that designated personnel are under no obligation to render the assistance requested and that such assistance may be rendered by an employee of the district who is not medically trained. There may not be any adult available for injections, catheterization or other procedures for which specific training is necessary. I/we hereby release the home school district, its board of education, its officials and employees, Mohican School in the Out-of-Doors, Inc., its board of trustees, officials and employees from any and all liability for damages or injury directly or indirectly resulting from the performance or failure of performance of the assistance requested. I/we agree to submit a revised statement signed by the physician if any information provided in Part II should change before my/our student goes to Mohican Outdoor School.

Signature of parent/guardian _____ **Date** _____

Child's Name _____ School _____

Address _____ Grade _____

Part II (completed by physician if physician prescribed medicine is being sent to Mohican)

Prescription Medicine must be in the original container

Name of Student _____ School _____

Name of Physician _____ Phone in case of emergency () _____

Physician's Address _____

Please list the name of drug, dosage and time or intervals dosage of drug is to be administered.

IF GENERIC DRUG IS BEING SENT, BOTH NAMES ARE NECESSARY.

The name on this form must match the medicine sent.

Name of drug & (generic name) Prescription	Dosage	How Often X/day	Brkfst. before after	Lunch before after	Supper before after	Bed-time	Other

Reason each medicine is needed _____

Date drug administration begins _____ Date drug administration ceases _____

Any severe adverse reactions that should be reported to the physician _____

Special instructions, if any, for administration or storage of the drug _____

Signature of Physician

 Date

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Signature of parent/guardian _____ **Date** _____

Child's Name _____ School _____

Address _____ Grade _____

Part III

Note: All medicine must be in the original container.

Name of drug & (generic name) Non-Prescription	Dosage	How Often X/day	Brkfst. before after	Lunch before after	Supper before after	Bed-time	Other

Reason each medicine is needed _____

Possible reactions that, if they occur, should be reported to the parent _____

Date medicine administration started _____ Date medicine administration ceases _____

Special instructions _____

Physician's name and address _____

Physician's telephone number () _____

Signature of parent/guardian _____ **Date** _____

Parent/Guardian's phone number () _____