

# Deep Portage Health and Permission Form

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

Parent or Guardian Name \_\_\_\_\_

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

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Health Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Physician \_\_\_\_\_

Clinic Name \_\_\_\_\_ Clinic Phone \_\_\_\_\_

## CURRENT HEALTH INFORMATION

- Asthma:** List triggers: \_\_\_\_\_ Treatment currently used? \_\_\_\_\_
- Diabetes:** Describe: \_\_\_\_\_
- Special dietary needs or food allergies:** Please describe. \_\_\_\_\_
- Other allergies:** List. \_\_\_\_\_ Does child carry epinephrine?  Yes  No
- Bleeding Disorder:** Describe: \_\_\_\_\_
- Seizures:** List medications and when used. \_\_\_\_\_
- Muscle-Bone-Joint condition:** Describe: \_\_\_\_\_
- Activity restrictions:** Describe: \_\_\_\_\_
- Heart condition:** Describe: \_\_\_\_\_
- Sleep Problems:**  bedwetting  sleepwalking  other: \_\_\_\_\_
- Other:** Describe. Use extra sheet if necessary. \_\_\_\_\_
- Date of last tetanus booster:** \_\_\_\_\_

## CURRENT MEDICATIONS

*Please list all prescription and over-the-counter medication your child will be taking while at Deep Portage. Include inhalers, nebulizer, ADHD medications, Tylenol, etc. Use extra sheet if 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 \_\_\_\_\_

**Medication #3:**  
Name of Medication: \_\_\_\_\_ Reason given: \_\_\_\_\_  
Amount given \_\_\_\_\_ Time Given \_\_\_\_\_  
Name of physician prescribing medication \_\_\_\_\_ Phone \_\_\_\_\_

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Permission and Emergency Authorization for the Above-Named Student:

- 1) The student has my permission to participate in the Deep Portage field trip.
- 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.

## Media Release:

Yes  No Do you give permission for photos and/or videos of your child to be used for the Deep Portage website, social media, or other promotional materials?

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

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SPACE FOR ADDITIONAL INFORMATION: