NC STUDENT REGISTRATION

Child's Name _____ Date of Birth _____
(Last) (First)

Age _____ Sex _____ Weight _____ Height _____

Address _____
(# & Street) (Town) (State) (Zip)

Guardian's Name(s) _____

Email Address _____

Home Telephone ( ) _____ Alternate Phone ( ) _____

Family Physician _____ Telephone _____

I give permission for (Name) _____ to attend Nature's Classroom

For the period of _____ as part of the outdoor education program

Of (School Name) _____

I understand that the director of Nature's Classroom may, if necessary for my child's health, have them hospitalized or use outside medical, surgical, or dental care. I also understand that the director and/or school leaders may dismiss my child from Nature's Classroom if, in their opinions, their conduct or influence is not in the best interest of the entire group. No refund is given if such action is taken for discipline reasons. Nature's Classroom has my permission to use my child's image, voice, and/or likeness for promotional purposes.

Date _____ Signature _____ Relationship _____

PART II – MEDICAL PERMISSION SLIP

Should your child become ill, get a headache, catch a cold, or have other minor medical or dental problems, do you give permission for the administration of basic first aid at the discretions of the NC staff?

YES _____ NO _____

Date _____ Signature _____ Relationship _____

If Ibuprofen or Tylenol needs to be administered, do you prefer:

IBUPROFEN _____ TYLENOL _____ OTHER (Specify) _____

Can your child take Benadryl? YES _____ NO _____

HOME AND HEALTH INFORMATION QUESTIONNAIRE

Child's Name: _____ Date of Session: _____

Your child's safety is our highest priority! The questions below are provided to give you a framework to provide us needed information. Please feel free to add whatever information you think will be helpful – **attach additional sheets if necessary**. We will share this information with your child's classroom teachers prior to his/her arrival.

1. Is this your child's first prolonged stay away from home? _____
2. Is this your child's first sleep away experience? _____
3. Has your child ever had a problem with homesickness? If yes, please explain briefly. _____

_____

4. Does your child have an issue with bed wetting? _____

Restrictions and Allergies

5. Are there any *physical* restrictions on your child's activities? Please include any special health concerns, e.g., recent hospitalization, fractured bones, etc.

_____

_____

_____

6. Are there any *food* allergies, intolerances, or dietary needs? Please include any specifics regarding type, reaction, severity, and treatment plans. * *If your child is a finicky eater, please specify 2-3 food choices.* *

_____

_____

_____

7. Are there any *non-food* allergies? Please list any other allergies, e.g., environmental, bees, medical, etc. and explain degrees of severity and current treatment.

_____

_____

8. Does your child have any sensory, physical, or cognitive disabilities? Yes ☐ No ☐ If yes, explain.

_____

_____

_____

9. Has anything happened *recently* in your child's life that may affect them *emotionally* while away from home. If yes, please explain.

_____

_____

10. Any additional information (use back if necessary):

_____

_____

MEDICATION ADMINISTRATION FORM

Prescribed daily medication is required at NC. All medications (including prescription, non-prescription and vitamins) must arrive in their **ORIGINAL CONTAINERS.** Please complete *all parts* of the following chart for all medications being sent or the medication cannot be administered. If more than four medications are needed, please copy this page.

CHILD'S NAME: _____

I hereby give permission for the staff of Nature's Classroom to administer to my child the following medication(s):

Medication	Dose (mg, tsp)	Time Medication Taken				
		Break-fast	Lunch	Dinner	Bed	Other

Comments (reason for taking medications, special considerations): _____

_____

_____

Your child will not be allowed to keep any medication in his/her dorm. **Prescribed medications must be in original container with pharmacy label containing Rx number, the name of the medication, the dosage, directions for administration and the child's name.** Whenever possible, a copy of the doctor's prescription or letter may be sent to clarify any discrepancies. All non-prescription medication must be in their original containers, clearly labeled with the child's name, name of the medication and direction for use.

Signed: _____ Date: _____

Relationship: _____

(Over the Counter) OTC Medications we can provide if necessary:

Tylenol/Acetaminophen, Motrin/Ibuprofen, Benadryl/Diphenhydramine, Claritin/Loratadine, Zyrtec/Cetirizine, Dramamine/Dimenhydrinate, Tums/Calcium Carbonate, Menthol Cough Drops