DUE Jan. 12, 2016

OREGON CONFERENCE OF SEVENTH-DAY ADVENTISTS
OFFICE OF EDUCATION OUTDOOR SCHOOL
19800 Oatfield Road
Gladstone, OR 97027
503-850-3547 Phone 503-850-3447 Fax
Theresa.Kramer@oc.npuc.org

EMERGENCY INFORMATION AND MEDICAL PERMISSION FORM

(Teachers, Chaperones, College Counselors over 18, High School Support Staff)

NAME ______________________________ BIRTHDATE ____/____/____ ☐ Male ☐ Female
Last First M MO / DAY / YR

ADDRESS ______________________________ PHONE: ______________

PERMANENT ADDRESS (if different than above) ______________________________

______________________________ PERMANENT PHONE ______________

PHYSICIAN'S NAME, ADDRESS & PHONE: ______________________________

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IN CASE OF EMERGENCY, PLEASE CONTACT:
(1) NAME ______________________________ RELATIONSHIP: ______________
ADDRESS: ______________________________ PHONE: ______________
(2) NAME ______________________________ RELATIONSHIP: ______________
ADDRESS: ______________________________ PHONE: ______________

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HEALTH AND MEDICAL INFORMATION

Please list any medical condition/concern, recent injury or hospitalization that might require special planning or consideration during your involvement with Outdoor School activities. ______________

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Specify any activities that are not allowed: ______________________________

Date of last tetanus (if known) ______________ Known allergies, i.e., hay fever, food, bee sting, drugs:

Explain: ______________________________

____

Special diet (explain): ______________________________

____

Recent exposure to infectious disease: ______________________________

Attach an additional sheet if there is any additional information you wish to share that is related to your well being.

MEDICATIONS

1. All counselors must turn in all prescription and over-the-counter medications to the nurse. Teachers and staff are encouraged to turn medications into the nurse as well.
2. Prescription and over-the-counter medications must be in original container.

I am taking the following medications and will bring them to Outdoor School. **(Required information)**

Medication	Reason	Dosage	Time	Prescribing Physician
				Contact Phone #

(OVER)

PERMISSION FOR ADMINISTRATION OF EMERGENCY CARE

In case of emergency, I hereby give permission to the physician/nurse selected by the Outdoor School to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for myself, as named above. I also give my permission for the Outdoor School personnel to arrange transportation in an emergency or if medical care is needed.

Signature ______________________________ **Date** ______________________

IF YOU HAVE A RELIGIOUS/PERSONAL OBJECTION

Because of religious convictions or personal objections, I am to receive **NO BLOOD or BLOOD PRODUCTS** ☐ (please check if applicable) or **NO MEDICATION in any form** ☐ (please check if applicable). I do understated that in the event of a life-death situation I will be administered life-sustaining first aid and medical care regardless of religious or personal convictions,

______________________________ **Date** ______________________

Signature

Please sign here ONLY if you have a religious or personal objection.

medstaff
10/27/04