STUDENT REGISTRATION FORM
RANCHO EL CHORRO OUTDOOR SCHOOL

PRINT STUDENT'S LAST NAME	STUDENT'S FIRST NAME	SESSION DATES	
SCHOOL	TEACHER		
Home address (number, street, city, state, zip code)	Home Telephone	Sex ☐ M ☐ F	Birth date (mo/day/yr)
Mother's (guardian) Name Work phone	Father's (guardian) Name Work phone		

If you cannot be reached in case of emergency, give name of person to be notified:

Name	Address	Telephone number
Name of Physician	Physician's address	Physician's telephone number
Name of your insurance company		Group or policy number

_____________________________ (**Student's full name**) has my permission to participate in the Rancho El Chorro Outdoor School program sponsored by the San Luis Obispo County Office of Education and student's home district. It is my understanding that this activity is made pursuant to the provisions of Education Code Sections #35350 and #35330 and that such sections provide that all persons participating in this activity shall be deemed to have waived all claims against the San Luis Obispo County Office of Education, the student's home district, or the State of California for injury, illness or death occurring during or by reasons of this activity. It is my further understanding that pupils will be under school supervision during this activity and transportation is being furnished by or as authorized by the student's home district.

In the event that I cannot be reached, I give permission for school authorities to obtain immediate medical aid or ambulance service. Further, as a parent or guardian of a student who will be attending Rancho El Chorro Outdoor School, I understand that an Outdoor School is not the same physical environment as a traditional school. There are certain inherent hazards associated with attending an outdoor school that a student does not encounter in a traditional school setting. For example, the student's "school day" is twenty-four hours long.

Understanding these circumstances, I agree that the County Superintendent, the Board of Education, each respective district, and all personnel, employees and agents of said County Superintendent, Board of Education, and each respective district are not responsible in any way for any injuries and/or damages which my child may suffer or sustain while attending or traveling to or from Rancho El Chorro Outdoor School. Accordingly, I hold these parties harmless and voluntarily waive any rights I may have to pursue any legal action against these parties for any such injuries and/or damages. I understand that this hold harmless agreement extends to any of these parties who may act pursuant to the above medical instructions or pursuant to the instructions of the attending physician or hospital. It is understood that the resulting expense will be the responsibility of the student's parent(s)/guardians(s).

☐ I hereby give permission for my child to be photographed or videotaped by employees of the Rancho El Chorro Outdoor School and the San Luis Obispo County Office of Education for educational and promotional use on television, on brochures or other printed materials, or on the County Office of Education website. Indicate if you do not give consent below.

☐ I **do not** give my permission for my child to be photographed or videotaped.

➔ **Signature of Parent or Guardian:**

HEALTH INFORMATION

1. If your child has been ill recently, please describe illness:

2. Check all applicable conditions of child and explain below.

☐ 1. Allergies and Hay Fever	☐ 5. Bed wetting	☐ 9. Heart trouble/murmur
☐ 2. Allergy to bee stings	☐ 6. Car Sickness	☐ 10. Poison Oak
☐ 3. Asthma	☐ 7. Epilepsy/convulsive disorder	☐ 11. Sinus trouble
☐ 4. Backaches or weak back	☐ 8. Headache	☐ 12. Sleep walking

Explain:

3. Date of last tetanus shot.	4. If child is on special diet, briefly describe dietary needs.
5. Exposure to communicable disease during past month? Please specify:	6. Any limitation on physical activity? Please specify:

It is not necessary for your child to have a physical examination before going to camp; however, we do recommend that they have had a tetanus shot within the last five years. **PLEASE NOTE**: If your child is under a doctor's care for an acute or chronic problem, your physician needs to know that your child will be away from home for three to five days. Please have your physician provide instructions on the reverse side of this form. All medications to be administered to your child must be listed on the reverse side and you must obtain a physician's signature authorizing administration of those medicines.

(PLEASE COMPLETE REVERSE SIDE)

REQUEST FOR MEDICATION AND PHYSICIAN'S INSTRUCTIONS

If your child will be bringing any medications to Rancho El Chorro Outdoor School it is required by law that you provide a physician's signature and note any special instructions below. **YOUR CHILD CANNOT BE GIVEN ANY MEDICATIONS WITHOUT A PHYSICIAN'S SIGNATURE**. All medications must be in the original container. All medications must be given to the teacher before boarding the bus to the Outdoor School.

PRINT STUDENT'S NAME (LAST, FIRST)

I request that my child (named above) be assisted by an authorized person in taking prescribed medication (description below) at the Outdoor School in compliance with the program's policies and procedures.

Signature of Parent/Guardian ➔	Date	Home telephone number

MEDICATIONS: Description(s) of any and all medications shall be completed by child's physician. Please attach additional paperwork if necessary.

Name of medication	1.	2.	3.
Purpose of medication			
Dosage prescribed			
Time schedule			
Dose form (liquid, tablet)			
Date of prescription			
Length of time medication is necessary			

Precautions, special instructions, possible adverse effect(s) or comments: If your child is under a doctor's care for an acute or chronic problem, your physician needs to know that the child will be away from home for three or five full days. Please have a physician give instructions for care of child in this space:

TO BE COMPLETED BY PHYSICIAN	Print Name of Physician	The above-named student, for whom the above medication is prescribed, is under my care.
	Address/City/Zip	**Signature of Physician** ➔
	Phone	Date signed (mo/day/yr)

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