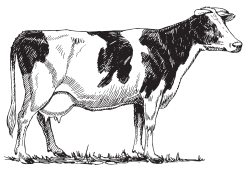

HEALTH & CONSENT HISTORY FORM

ONE FORM NEEDS TO COMPLETED PER STUDENT

THIS FORM IS REQUIRED BY FARM CAMP AND IS CONFIDENTIAL. Please do not send your child to Farm Camp if they have had a temperature of 100 degrees or more within the last 24 hours. IF THEY ARRIVE WITH A TEMPERATURE OVER 100 DEGREES THEY WILL BE SENT HOME. Also, do not send your child to Farm Camp if they have a contagious disease or have recently been exposed to one.

Student's Name: _____ Date of Birth: _____

Gender: Male Female

Parent/Guardian Name: _____

Address: _____

_____

Home Phone: _____ Cellphone: _____ Business: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

HEALTH HISTORY

Has/does your child:	YES	NO
1. Wear contact lenses or glasses?	☐	☐
2. Been under a physician's care recently?	☐	☐
3. Have a chronic or reoccurring illness?	☐	☐
4. Had asthma?	☐	☐
5. Ever been hospitalized	☐	☐
6. Have diagnosed migraines?	☐	☐
7. Ever had seizures?	☐	☐
8. Have any skin problems (itching, rash, etc)?	☐	☐
9. Had problems with diarrhea/constipation?	☐	☐
10. Have any problems with sleepwalking?	☐	☐
11. Have a history of bed-wetting?	☐	☐
12. Abnormal menstrual history?	☐	☐
13. Have an eating disorder?	☐	☐
14. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any 'Yes' answers:

_____

_____

_____

15. Date of last physical:

_____

(write unknown if unsure)

16. Date of last tetanus shot:

_____

(write unknown if unsure)

17. My child is allergic to (please explain any reaction):

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATION FORM

This form is required to bring any medication (even over the counter) to Farm Camp (Farm Camp). PLEASE NOTE: IF YOU ARE BRINGING PRESCRIPTION MEDICATION, YOUR PHYSICIAN MUST SIGN THIS FORM. We are unable to administer any prescription medications, including inhalers, without your doctor's signature and your child will not be permitted to stay at Farm Camp.

Student's Name: _____ Age: _____

• **All medication must be in the original package/bottle**. Prescription Medication Labels Must State: Patient Name, Physician Name, Medication Name, Dosage (Amount), and the Frequency (When). If your child takes injections, they must be able to inject themselves. If they cannot inject themselves, they cannot be accepted u\into our program.

• **The information written on this sheet must be exactly the same as the information on the medication's prescription label.** If the medication label and the information on this sheet do not match, we will be unable to give your child the prescription medication, and you will be asked to come and pick up your child.

• As a guide, Farm Camp regular medicine calls are held at: 8:00 am; 12:00 pm; 6:00 pm; and 9:00pm (corresponding to breakfast, lunch, dinner and bedtime each full day at Farm Camp).

STEP 1: ARE YOU BRINGING PRESCRIPTION MEDICATION (including inhalers)?

If any of your medications are prescription medications, you must have a physician signt his form. We cannot administer prescription medication without a physician's signature.

Name of Medicine	Dosage	Frequency	Reason for Medication	Possible Reaction

Print Physician's Name: _____ Telephone: _____

Physician's Signature: _____ Date: _____

STEP 2: ARE YOU BRINGING OVER THE COUNTER/NON-PRESCRIPTION MEDICATION?

No physician's signature is necessary for non-prescription medication. Please check the label to make certain that your child is the correct age to take the medication.

Name of Medicine	Dosage	Frequency	Reason for Medication	Possible Reaction

STEP 3: PLEASE READ AND SIGN BELOW.

I, the undersigned, who is the parent/guardian of the child named above, request the prescribed medication be administered to my child in accordance with my physician's instructions as indicated above. I understand that Farm Camp (Highland Springs Conference and Training Center) is not legally obligated to administer medication to my child, and therefore, I agree to hold Farm Camp, Highland Springs Conference & Training Center, WELS America Inc. and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them. I will notify Farm Camp immediately if I change physicians or if the medication is changed.

Parent/Guardian Signature: _____ Date: _____

INSURANCE AND DOCTOR INFORMATION

Is your child covered by medical/hospital insurance? Yes No Group/Policy# _____

Please list the name and billing address of the carrier:

Name of insured: _____ Relationship to student: _____

Social Security Number of policy holder or insurance ID number: _____

Name, address, and phone number of your family doctor:

_____

_____

_____

I, the undersigned parent or legal guardian of the child named above, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical treatment rendered by medical or emergency room staff licensed under the provisions of the Medicine Practice Act, or dentist licensed under the provisions of the Dental Practice Act and on the staff of any general hospital in the state of California, Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care deemed advisable by aforementioned physicians in the exercise of the doctor's best judgment. It is understood that every effort will be made to contact the undersigned prior to rendering treatment to the patient, but none of the above treatment will be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. Any medical related expenses will be the sole responsibility of the parent or legal guardian of the injured/sick party. I expressly waive any claim against Highland Springs Conference & Training Center, Farm Camp, WELS America Inc. and its employees, ATI, Inc., for injuries, sickness or pain and suffering relating thereto in excess of the stated policy limits.

☐ Please check this box if you do not authorize Farm Camp to give your child common over the counter remedies in appropriate age/weight dosages in the event of a minor illness at Farm Camp (ex. non-aspirin pain relief, cough medicine, etc.).

Parent/Guardian Signature: _____ Date: _____

This form must be signed and dated for your child to attend Farm Camp.

Please fax back to 951-845-8090
or e-mail to admin@123farm.com