



**COLOMA INSTITUTE-TEAM DISCOVERY**  
**Medical Information and Release Form**

Group #: \_\_\_\_\_

**PLEASE PRINT IN INK:**

Participant's Name:	Boy / Girl (circle)	Date of Birth:
School/Organization Name:	Teacher:	
Home Address:	City:	Zip:
Family Physician:	Physician Phone:	
Insurance Company:	Insurance Co. Policy #:	

**MEDICATIONS:**

Medications, including over-the-counter medications (OTC), can only be administered by designated trained personnel from your child's school, provided that this form is signed by the authorized health care provider AND the parent or guardian. Coloma Institute does not stock OTC medications. OTC medications include, but are not limited to: allergy remedies (Benadryl, etc.), antiseptic and/or topical ointments, cold remedies, insect bite remedies, aspirin, non-aspirin substitutes, and poison oak remedies. Medications must be packaged individually in pharmacy-prepared containers (with only the amount to be administered) and given directly to your school personnel. Medication labels must include:

- Student's name
- Authorized health care provider
- Name of medication
- Dose of medication
- Method of administration
- Time of administration

**PHYSICIAN'S STATEMENT OF REQUIRED MEDICATION:**

\_\_\_\_\_ should be given the following medication as designated below:  
 Student's name \_\_\_\_\_ Please attach additional sheet(s) as necessary.

Prescription Medication:	Dosage:	Method of administration:	Time of administration:	Special instructions and/or precautions:
OTC Medication: list allergy remedies, antiseptic and/or topical ointments, cold remedies, insect bite remedies, aspirin, poison oak remedies, etc.				

Please allow \_\_\_\_\_ to keep an inhaler with him/her at all times. He/she is competent to safely self-administer medication.

Please allow \_\_\_\_\_ to keep an epi-pen with him/her at all times. He/she is competent to safely self-administer medication.

Physician Name: _____	Phone: _____
Physician Signature: _____	Date: _____

If necessary, should first aid be given? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last Tetanus shot \_\_\_\_/\_\_\_\_/\_\_\_\_



**EMERGENCY CONTACTS:**

Parent/guardian:	Relation:
Phone:	Alternate Phone:

Parent/guardian:	Relation:
Phone:	Alternate Phone:

If a parent/guardian cannot be contacted in case of emergency, please contact:

Name:	Relation:
Phone:	Alternate Phone:

**PARENT/GUARDIAN RELEASE**

RISKS	PREVENTION
Getting hit by a falling object.	Be alert. Look up before walking near or under course. Wear your helmet at all times!
Hair, clothing or jewelry getting caught in pulleys or other parts of the Challenge Course.	Tie long hair back. Remove rings, dangling earrings, watches, etc. and wear proper clothing.
Injuries or discomfort caused by improper use of harness.	Have harnesses checked by two different staff members.
Scrapes, cuts, and/or splinters.	Climb within abilities. Wear proper clothing.
Serious injury and/or death.	Wear proper safety gear. Make sure belayer is ready before you climb.

I, \_\_\_\_\_ (Parent/Guardian's name if participant is under 18 years of age), have read the above and fully understand the rigorous nature of the Challenge Course experience and the risks associated with it. I also realize that additional risks and/or dangers not outlined above may exist.

(Participant's Name) \_\_\_\_\_ has my permission to attend the Coloma Institute as a school sponsored event. I recognize that in accordance with the California Department of Education's Code of Regulations, designated trained personnel from my child's school will be administering any medications described in the Physician's Statement. The designated trained personnel may communicate with the physician with regard to this medication. For the best interest of my child, a copy of this Medical Information and Release Form will be provided to his/her assigned parent counselor, and relevant information will be communicated to Institute staff on a need to know basis, ensuring strict confidentiality of any sensitive information.

(Participant's Name) \_\_\_\_\_ is in good health, however, in case of a medical or surgical emergency, I hereby authorize the physician selected by the Institute to secure all proper and required treatment for my child. All expenses for treating my child shall be paid for by the parent or guardian.

★ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian if participant is under 18 years of age)

If my son/daughter must be removed from the school for illness or disciplinary reasons, it will be my responsibility to arrange transportation home for him/her.

★ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian if participant is under 18 years of age)

**Please complete & return to group coordinator two weeks prior to trip.**