



COLOMA OUTDOOR DISCOVERY SCHOOL

Adult Medical Information & Release Form

Date of Attendance: _____/_____/_____

School Name:	
Name:	Date of Birth:
Physician (if applicable):	Physician's Contact Number:
Insurance Company (if applicable):	Policy #:

In case of emergency, please contact:

1) Name:	Relation:
Home Phone:	Work Phone:
2) Name:	Relation:
Home Phone:	Work Phone:

Do you take any prescription medications that we should be aware of?

Medication:	Dosage:	Frequency:

Do you have a condition or illness such as diabetes, asthma, allergies, or other, which we should be aware of? If so, please explain (use the back of this form if necessary):

- If necessary, should First Aid be given? Yes _____ No _____
- What is the approximate date of your last Tetanus Shot? ____/____/_____

I hereby authorize Coloma Outdoor Discovery School to provide medical, nursing or surgical care, including care rendered through the nearest physician or hospital for any emergency which may arise while I am in attendance at the Coloma Outdoor Discovery School. I will assume full financial responsibility for all medical, nursing, or surgical care, including transportation.

Signature _____ Date: _____

If you have not authorized medical treatment by your signature on the above line, please state your reasons on the back of this form and sign below:

Signature: _____ Date: _____

Please return to classroom teacher two weeks prior to trip.