

KEEP* OUTDOOR SCIENCE SCHOOL STUDENT REGISTRATION FORM

*KEEP (The acronym for Kern Environmental Education Program)

Name: _____ Date of Birth: _____ Dates at KEEP: _____
Address: _____ Home Phone: _____ School: _____
City/Zip: _____ Work Phone #1: _____ Teacher: _____
Parent/Guardian: _____ Work Phone #2: _____
Work Address: _____ Cell Phone #1: _____
City/Zip: _____ Cell Phone #2: _____

NOTE: Registration of your child constitutes permission for the child to participate in all activities undertaken by the class at KEEP under the direction of the Kern County Superintendent of Schools.

HEALTH INFORMATION NECESSARY:

- Do you know of any health condition that would limit outdoor activity?
 - Recent surgery or illness? (Please specify) _____
 - Recent broken bones, sprains, etc.? _____
 - Asthma, heart condition? _____
 - Other physical limitations? _____
- Is your child currently taking medication? If so, please have physician complete KEEP Pupil Medication Form.
- Does your child have a specialized health care condition? If so, please have physician complete KEEP Physician's Authorization to Attend Form. Also, contact Director Tom Anspach (661-871-1883) for approval and notify your child's teacher immediately if any of the following serious medical conditions apply: 1) Any medications requiring injections (i.e. Epipen or Glucagon), 2) Diabetes, 3) Severe bee sting reaction, 4) Severe food or nut allergy, 5) Mobility limitations, 6) Severe asthma (i.e. requiring nebulizer or activity restrictions), 7) Seizures, 8) Respiratory Restrictions (i.e. limiting activity), 9) Recent hospitalization or 10) Other serious health conditions.
- Has your child been exposed to a communicable disease within the past twenty-one days? Yes No
If yes, what disease? _____ Date exposed: _____
- In order to protect children from possible embarrassment, the following information is necessary: (Please be specific)
 - Does your child walk in his/her sleep? Yes No
 - Does your child wet the bed at night? Yes No
 - Are there other factors that may affect the care of your child? _____
Comments: _____
- Allergy Information (please be specific):
 Medication Allergies _____ Vegetarian _____
 Insect Allergies _____ Food Allergies _____
 Other Allergies _____
- If you cannot be located in case of an accident, who should be called? Name: _____
Address: _____ Phone: (____) _____ Cell Phone: (____) _____
- Has your child had his/her tetanus series or booster? No Yes If yes, what date? _____
- Is your child covered by:
 Medi-Cal? If yes, card number _____ (attach copy of card)
 Medical Insurance? (company name) _____ Policy Number _____ (attach copy of card)

If a serious emergency should arise, it might be necessary for a physician to attend to your child before the KEEP Outdoor School staff could get in touch with you. Such care can be provided only if you sign the following AUTHORIZATION FOR MEDICAL TREATMENT.

AUTHORIZATION FOR MEDICAL TREATMENT. I hereby authorize the KEEP Outdoor School to provide medical and/or surgical care, through the facilities of an appropriate medical facility for the above named student in any emergency which may occur while he/she is in attendance at the KEEP Outdoor School and I further authorize release of such medical information pertaining to the student as the treating physician or medical facility may require. **This statement must be signed before your child can be accepted at the KEEP Outdoor School.**

Parent/Guardian Signature (sign in ink)

AUTHORIZATION FOR TETANUS SHOT OR BOOSTER. I hereby give my permission for the KEEP Outdoor School to authorize tetanus shot or booster if deemed advisable by a physician at the appropriate medical facility.

Parent/Guardian Signature (sign in ink)

I hereby give permission for my child to be photographed or videotaped by employees of the KEEP Outdoor School and the Kern County Superintendent of Schools for educational and promotional use on television, on brochures or other printed materials, or on the KEEP web site.

Parent/Guardian Signature (sign in ink)