

**KEEP * OUTDOOR SCIENCE SCHOOL
COUNSELOR REGISTRATION FORM**

Name _____ Date from _____ to _____
Address _____ Elementary School _____
City _____ Zip _____ High School (if applicable) _____
Date of Birth _____ Phone (____) _____
Name of Parent or Guardian (if living at home) _____
Business Address _____ Phone (____) _____

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

HEALTH INFORMATION NECESSARY:

1. Do you know of any health factor that would limit outdoor activity? _____
 - a. Recent surgery or illness? (Please specify) _____
 - b. Recent broken bones, sprains, etc.? _____
 - c. Asthma, heart condition? _____
 - d. Other physical limitations? _____
2. **SPECIFIC LIMITATIONS ON ABOVE CONDITIONS** _____
 - a. What medications are you currently taking? _____
3. Name of Physician _____ Phone (____) _____
4. Has your child been exposed to a communicable disease within the past twenty-one days? Yes No.
If yes, what disease? _____ Date exposed? _____
5. In case of an accident, who should be called? Name _____
Address _____ Phone (____) _____
6. Has your child had a tetanus series or booster? Yes No. If yes, what date? _____
7. Is your child covered by: Cal-Med? If yes, card number (attach copy of card) _____
 Medical Insurance? If yes, company's name _____ Policy Number (attach copy of card) _____
8. Are there allergic reactions to any medicines in case of emergency? Yes No. If yes, what type? _____
9. Food Allergies: _____ Insect Allergies: _____
Other Allergies: _____ Vegetarian: _____

If a serious emergency should arise, it might be necessary for a physician to attend to your child before the KEEP Outdoor Science School Staff could get in touch with you. Such care can be provided only if you sign the following **AUTHORIZATION FOR MEDICAL TREATMENT**. The statements below must be signed **before** your child can be accepted at the KEEP Outdoor Science School.

AUTHORIZATION FOR MEDICAL TREATMENT. I hereby authorize the KEEP Outdoor Science School to provide medical and/or surgical care, through the facilities of an appropriate medical facility for (name of student) _____ in any emergency which may occur while he/she is in attendance at KEEP Outdoor Science School and I further authorize release of such medical information pertaining to the student as the treating physician or medical facility may require.

Signature (sign in ink)

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

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.

Signature (sign in ink)

KEEP COUNSELOR CONTRACT
(Under 18 years of age)

KEEP is depending on you for five days of concentrated effort to succeed as a counselor. Please read, initial each statement, and sign at the bottom of this contract. Turn this contract in with your medical forms. Please note that your parent or guardian's signature is also required if you are under 18 years old.

As a counselor at KEEP I understand that:

_____ I will be assigned to specific responsibilities concerning about 7-12 elementary students.

_____ I will be looked up to by these elementary age students which will require me to be an excellent role model at all times.

_____ I will be expected to follow all KEEP rules along with the students and I will support and enforce those rules.

_____ If a student is misbehaving or breaking a rule, I will be expected to take the student(s) to his/her teacher or a staff member.

_____ The KEEP staff and classroom teachers will be available 24 hours per day to assist and support me with any situation I may encounter.

_____ If I do not live up to the above expectations I will be dismissed from my counselor responsibilities and sent home immediately.

As a counselor at KEEP I agree that:

_____ I will **not** use inappropriate language during my KEEP week.

_____ I will **not** hit, touch, or raise my voice to any student or other counselor for any reason.

_____ I will **not** use alcohol, tobacco products or any other drugs during my KEEP week.

_____ I will **not** discuss sexual or religious issues of any kind with the students, nor will I tolerate uncomplimentary remarks regarding one's religious, gender, or ethnic group.

_____ I will treat all students with kindness, respect and dignity.

I have read the above counselor contract and understand my responsibilities as a KEEP counselor.

Please sign your full name

date

I understand that if my child does not fulfill his/her KEEP responsibilities as outlined above, the KEEP staff and classroom teachers must dismiss him/her immediately and that I will be notified and expected to transport my child home immediately.

Parent/Guardian signature

date