FOOTHILL HORIZONS OUTDOOR SCHOOL
ADULT HEALTH FORM

Health/ Permission & Medication forms are scanned to foothillhorizons@stancoe.org
3 weeks prior to attendance

Name: ______________________________ Date of Birth: ____/____/____

Role this week (check one): ☐ Teacher ☐ Paraprofessional ☐ Parent Shadow ☐ Support Staff

School: ______________________________ District: ____/____/____

Address ______________________________
Street City Zip

Cell: ______________________________ Other Phone: ______________________________

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: ____________________ Relationship: ____________________ Phone: ____________________

Name: ____________________ Relationship: ____________________ Phone: ____________________

HEALTH INFORMATION:

YES NO

☐ ☐ 1. Do you have any **health concerns** (heart condition, diabetes, high blood pressure)?

____

☐ ☐ 2. Do you have any serious allergies to foods, insect stings, medications, or other substances?
If YES, what are you allergic to?

Allergen:	Life threatening: ☐ Yes ☐ No	Epi Pen: ☐ Yes ☐ No	☐ Contact/touch	☐ Ingestion/eating	☐ Airborne/Inhalation
Allergen:	Life threatening: ☐ Yes ☐ No	Epi Pen: ☐ Yes ☐ No	☐ Contact/touch	☐ Ingestion/eating	☐ Airborne/Inhalation
Allergen:	Life threatening: ☐ Yes ☐ No	Epi Pen: ☐ Yes ☐ No	☐ Contact/touch	☐ Ingestion/eating	☐ Airborne/Inhalation
Allergen:	Life threatening: ☐ Yes ☐ No	Epi Pen: ☐ Yes ☐ No	☐ Contact/touch	☐ Ingestion/eating	☐ Airborne/Inhalation

3. Special Diets: Are there foods you CANNOT eat?
Are there foods you **CANNOT** eat?

☐ ☐ ☐ No beef ☐ No pork ☐ Vegetarian ☐ Vegan ☐ Other ______________________________

*For multiple and/or life threatening allergies email foothillhorizons@stancoe.org a description. All Special Diets must be in writing! Refer to **Special Diet Policy** on our website.*

☐ ☐ 4. Do you take any medication? If yes, please list: ______________________________

____

Physician: ______________________________ Phone: ____________________
(If non, state "NONE")

Insurance Carrier: ______________________________ ID#: ____________________

I hereby consent to emergency treatment if the need arises.

Signature: ______________________________ Date: ____________________