



FOOTHILL HORIZONS OUTDOOR SCHOOL

ADULT HEALTH FORM



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

Name: _____ Gender: Male Female

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

Which student(s) you are supporting: _____

School: _____ District: _____

Email: _____

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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Epi Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Contact/touch	<input type="checkbox"/> Ingestion/eating	<input type="checkbox"/> Airborne/Inhalation
Allergen:	Life threatening: <input type="checkbox"/> Yes <input type="checkbox"/> No	Epi Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Contact/touch	<input type="checkbox"/> Ingestion/eating	<input type="checkbox"/> Airborne/Inhalation
Allergen:	Life threatening: <input type="checkbox"/> Yes <input type="checkbox"/> No	Epi Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Contact/touch	<input type="checkbox"/> Ingestion/eating	<input type="checkbox"/> Airborne/Inhalation
Allergen:	Life threatening: <input type="checkbox"/> Yes <input type="checkbox"/> No	Epi Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Contact/touch	<input type="checkbox"/> Ingestion/eating	<input type="checkbox"/> 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: _____



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