Web of Life Field (WOLF) School MEDICAL HISTORY FORM

Child's Name _____ (M F) Birthdate _____ Age_____
Last First

Address_____ City_____ ZIP_____

School _____ Teacher _____

The following information is required to ensure that your child's needs are met while attending the WOLF School. Information is confidential and will be made available only to those who are directly responsible for your child's well-being, In the event of an emergency, every effort will be made to contact the parent/designated individual. **For their safety and well being, NO student will be allowed to attend without a completed and signed Medical History Form**. If your student needs to take medication**, you and your doctor must fill out the Medication Authorization Form also. X =Signature required.**

Name of Parent/Guardian_____ Relationship _____

Home Ph. _____ Work Ph. _____ Alt. # _____

If Parent/Guardian cannot be reached in an emergency, please contact:

Alternate Contact _____ Relationship _____

Home Ph. _____ Bus. Ph. _____ Alt. # _____

Family Physician _____ Phone _____

Student Health Insurance Co._____Policy #_____

Address _____ City_____Zip_____

Health Information Necessary for Child's Care

Please list any physical or behavioral conditions that the school staff should be aware of, i.e., sleepwalking, epilepsy, fainting, asthma, hyperactivity, nose bleeds, bedwetting, etc. Attach an extra sheet if necessary. Please be specific.

_____

Is your child allergic to any foods, medications or insect bites? (Y N) If 'yes' then please specify nature of allergies:

_____

Is your child **allergic to bees**? (Y N) **allergic to nuts**? (Y N) Carrying an epipen? (Y N) Possible reactions: _____

_____Date of last tetanus shot:_____Recent surgery or illness_____

Attach an extra sheet for additional information regarding allergies, possible reactions or other necessary information.

My child/ward, _____ has my permission to attend the Web of Life Field School in conjunction with their regular school program. My child/ward is in good health and I accept all financial responsibility for my child's attendance. IN CASE OF MEDICAL OR SURGICAL EMERGENCY, I hereby authorize the physician selected by the Program Director to secure all proper and required treatment for my child/ward.

I have read the Behavioral Expectations & Discipline Policy with my child/ward and s/he understands the expectations for students attending the Web of Life Field School.

X Parent/Guardian Signature_____ Date_____

I agree that any photographs of my child/myself taken by any WOLF School staff or others authorized by them, or any photographs, video, writing, artwork and/or testimonials submitted my child/myself to the WOLF School shall be the property of the WOLF School and may be used by the WOLF School and others authorized by them at its discretion for any publicity, marketing and/or advertising purposes, and I hereby consent to and authorize such use without restriction.

Parent/Guardian Signature_____ Date_____