

NW REGIONAL EDUCATION SERVICE DISTRICT  
NW OUTDOOR SCIENCE SCHOOL  
5825 NE RAY CIRCLE, HILLSBORO, OR 97124  
Phone: (503) 614-1402 Fax: (503) 614-3182

OFFICE USE ONLY	
CAMP	_____
WEEK	_____

**MEDICAL NEEDS FORM:** Complete this form if you have students with a physical or medical need such as a chronic/serious illness (diabetes, epilepsy, etc...), student with speech/hearing impairment or a student who requires the use of a wheelchair or adaptive devices. Return it to the Outdoor School office **as soon as possible** to allow for special planning. Include **SEVERE dietary restrictions and/or allergies**. **If you need additional forms, please make copies.**

Teacher's name \_\_\_\_\_ School \_\_\_\_\_  
School Phone # \_\_\_\_\_ Teacher E-Mail: \_\_\_\_\_

<p><b>Student's Name</b> _____</p> <p>Life threatening Allergy: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Carries an EPI pen: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is student on a 504 Plan: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Uses a wheelchair or Adaptive Device? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Attending with an Aide? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Requires bathroom aide (toileting &amp; showering): Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Student Need: _____</p> <p>_____</p> <p>_____</p> <p>Special Education teacher or other individual who may have additional information: Name: _____ Email: _____ Phone: _____</p>
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