NORTHWEST REGIONAL EDUCATION SERVICE DISTRICT
Northwest Outdoor Science School
5825 NE Ray Circle Hillsboro, OR 97124
Phone: (503) 614-1402 Fax: (503) 614-3182

EMERGENCY INFORMATION AND MEDICAL PERMISSION FORM

(ODS Staff, Teachers/Aides, College Age Student Leaders etc)

NAME _____ BIRTHDATE ____/____/____ Gender (circle one): M F X
Last First M MO / DAY / YR

ADDRESS _____ PHONE: _____

PERMANENT ADDRESS (if different than above) _____

_____ PERMANENT PHONE _____

PHYSICIAN'S NAME, ADDRESS & PHONE: _____

_____

IN CASE OF EMERGENCY, PLEASE CONTACT:
NAME _____ RELATIONSHIP:_____
ADDRESS: _____ PHONE: _____
NAME _____ RELATIONSHIP:_____
ADDRESS: _____ PHONE: _____

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HEALTH AND MEDICAL INFORMATION

Please list any medical condition/concern, recent injury or hospitalization that might require special planning or consideration during your involvement with Outdoor School activities._____

_____

_____

_____

Specify any activities that are not allowed: _____

Date of last tetanus shot (if known) _____Known allergies: ☐ hay fever ☐food ☐bee sting ☐drugs ☐ latex ☐
☐ Other (list) _____Explain reaction: _____

_____

Special diet (explain): _____

_____

Recent exposure to infectious disease: _____

Attach an additional sheet if there is any additional information you wish to share that is related to your well being.

MEDICATIONS

1. All counselors must turn in all prescription and over-the-counter medications to the nurse to be kept in the infirmary. Teachers and staff are encouraged to turn medications into the nurse as well.
2. Prescription and over-the-counter medications must be in original container.

I am taking the following medications and will bring them to Outdoor School. **(Required info from college counselors)**

Medication	Reason	Dosage	Time	Prescribing Physician

(OVER)

CIRCLE YOUR COVID-19 VACCINE MANUFACTURER &
LIST THE DATES YOU RECIVED DOSES

Pfizer Moderna Johnson & Johnson _____ _____ _____ **Not Vaccinated**

PERMISSION FOR ADMINISTRATION OF EMERGENCY CARE

In case of emergency, I hereby give permission to the physician selected by the Outdoor School to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for myself, as named above. I also give my permission for the Outdoor School personnel to arrange transportation in an emergency or if medical care is needed.

_____ _____

Signature **Date**

IF YOU HAVE A RELIGIOUS/PERSONAL OBJECTION

If you have a religious/personal objection to medical treatment please check the appropriate boxes:

☐ **NO BLOOD or BLOOD PRODUCTS** ☐ **NO MEDICATION in any form.**

I do understated that in the event of a life-death situation I will be administered life-sustaining first aid and medical care regardless of religious or personal convictions.

_____ **Date** _____

Signature

Please sign here ONLY if you have a religious or personal objection.