STUDENT MEDICAL FORM

PLEASE PRINT CLEARLY

I/We, the parent(s) or guardian(s) of the participant named below, wish to register my/our child in the Maritime Museum of San Diego Overnight Program. Dates attending _____ to _____.

Participant's Name (Last)_____ (First) _____

Home Phone (____) _____ Birth date ____ / ____ / ____

Address _____ City _____ State _____ Zip _____

In case of emergency, please notify: Parent(s)/Guardian(s)

Name_____

Address _____City _____ State _____ Zip _____

Daytime Phone Number (____) _____ *Business Number (____) _____

*Employer _____

Alternate Person in case of emergency, please notify: _____ at (____) _____

Name/Phone number of Family Physician_____

Name/Number of family medical insurance carrier_____

* For Medical Insurance Claims only

PARTICIPANT HEALTH INFORMATION

1. Does the participant have any physical or medical conditions or restrictions? Yes ____ No ____ Vegetarian ____

If so, please describe:_____

If your child has a special medical or physical condition, your physician should understand that the participant will be away from home for two full days. Please have your physician write a note indicating agreement that the participant is fit enough to fully participate in the program and to also include any special instructions.

2. Is your child subject to any of the following? Please circle:

Homesickness Sleepwalking Bed wetting (send extra bedding) Car sickness

3. Does your child have any dietary requirements or restrictions? Yes ____ No ____

If so, please describe:_____

4. Does your child have any allergies that may be of concern? Yes ____ No ____

If so, please describe the severity:_____

5. Has the participant recently been ill or exposed to any communicable diseases? Yes ____ No ____

If so, please explain:_____

6. MEDICATION

In order for your child to receive any prescription medication during the Overnight program, a parent or guardian and your child's physician must complete an ADMINISTRATION OF MEDICATION form. For prescription medication, a form must be completed for each medication prescribed for the period you child will attend the program. The prescription container must be clearly labeled with the following information:

a. Participant's full name b. Physician's name c. Physician's phone number
d. Name of medication e. Dosage f. Expiration date of Rx.
Each medication must be in a separate container.

In order for your child to **bring** and receive any non-prescription medication (headache remedies, upset stomach remedies) during the Overnight program, an ***ADMINISTRATION OF MEDICATION*** form must be completed by parent or guardian and your child's physician. Any non-prescription medication you send with your child must be in the original container and clearly labeled with your child's name. **No child will be allowed to take any non-prescription medication unless this form is completed, has a physician's signature, and the medication is sent to the program with the teacher-in-charge.**

If your child is under a doctor's care for an acute or chronic condition, your physician should understand that the child will be away for two full days. Any special instructions should be attached to this form.

AUTHORIZATION AND CONSENT FOR PARTICIPANT TREATMENT

1. The Maritime Museum of San Diego is located approximately 10 minutes from Scripps Mercy Hospital at 4077 5th Ave. Parents will be notified immediately when a child becomes injured or seriously ill, and aid will be according to the parent's wishes. Arrangements will be made with the parent(s) to pick up their child if desired.

2. A child will not be released during the program to anyone other than parent or guardian except on written or verbal request by the parent or guardian.

3. I/We _____ do hereby authorize the Maritime Museum of San Diego staff as agents for the undersigned to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the California Medical or Dental Practices Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at office of said physician or said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of aforesaid agents to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of Civil Code of California. This authorization shall remain in effect until _____ (date) unless revoked sooner in writing and delivered to said agents.

_____ _____
Signature of Adult Participant or Parent/Legal Guardian of Child Date

If it is desired that no medical treatment be given to the participant please provide the necessary instruction and sign here.

_____

_____

_____ _____
Signature of Adult Participant or Parents/Legal Guardian of Child Date