RANCHO EL CHORRO OUTDOOR SCHOOL
SUMMER OUTDOOR ADVENTURES for KIDS (S.O.A.K.) CAMP
REGISTRATION FORM

PRINT CHILD'S LAST NAME	CHILD'S FIRST NAME	Circle session(s) desired: Session #1: June 12-16 Session #2: June 19-23 Session #3: June 26-30	
Home address (number, street, city, state, zip code)	Home Telephone	Sex M F	Birth date (mo/day/yr) Circle t-shirt size: XS S M L XL
Mother's (guardian) Name Work or cell phone	Father's (guardian) Name Work or cell phone		

If you cannot be reached in case of emergency, give name of person to be notified:

Name	Address	Telephone number
Name of Physician	Physician's address	Physician's telephone number
Name of your insurance company		Group or policy number

_____ (Child's full name) has my permission to participate in the Rancho El Chorro Outdoor School SOAK Camp sponsored by the San Luis Obispo County Office of Education. It is my understanding that this activity is made pursuant to the provisions of Education Code Sections #35350 and #35330 and that such sections provide that all persons participating in this activity shall be deemed to have waived all claims against the San Luis Obispo County Office of Education, or the State of California for injury, illness or death occurring during or by reasons of this activity. It is my further understanding that pupils will be under school supervision during this activity. In the event that I cannot be reached, I give permission for school authorities to obtain immediate medical aid or ambulance service. Further, as a parent or guardian of a child who will be attending SOAK Camp at the Rancho El Chorro Outdoor School, I understand that an Outdoor School has certain inherent hazards associated with a natural environment.

Understanding these circumstances, I agree that the County Superintendent, the Board of Education, each respective district, and all personnel, employees and agents of said County Superintendent, Board of Education, and each respective district are not responsible in any way for any injuries and/or damages which my child may suffer or sustain while attending the SOAK Camp at the Rancho El Chorro Outdoor School. Accordingly, I hold these parties harmless and voluntarily waive any rights I may have to pursue any legal action against these parties for any such injuries and/or damages. I understand that this hold harmless agreement extends to any of these parties who may act pursuant to the above medical instructions or pursuant to the instructions of the attending physician or hospital. It is understood that the resulting expense will be the responsibility of the child's parent(s)/guardians(s). I hereby give permission for my child to be photographed or videotaped by employees of the Rancho El Chorro Outdoor School and the San Luis Obispo County Office of Education for educational and promotional use on television, on brochures or other printed materials, or on the County Office of Education website. Indicate if you do not give consent below.

I **do not** give my permission for my child to be photographed or videotaped *(please initial here).*

➔ **Signature of Parent or Guardian:** **Email address:**

HEALTH INFORMATION

1. Check all applicable conditions of child and explain below.
    1. Allergies and Hay Fever
    2. Allergy to bee stings
    3. Asthma
    4. Sensitivity to Poison Oak
    5. Sinus trouble
    6. Orthopedic limitations

Explain:

2. Date of last tetanus shot.	3. Any limitation on physical activity? Please specify:

Please complete other side if sending any medications with your child.

REQUEST FOR MEDICATION AND PHYSICIAN'S INSTRUCTIONS

If your child will be bringing any medications to SOAK Camp at the Rancho El Chorro Outdoor School, it is required that you provide a physician's signature and note any special instructions below. **YOUR CHILD CANNOT BE GIVEN ANY MEDICATIONS WITHOUT A PHYSICIAN'S SIGNATURE**. All medications must be in the original container. All medications must be given to the Rancho El Chorro staff upon arrival.

PRINT STUDENT'S NAME (LAST, FIRST)

I request that my child (named above) be assisted by an authorized person in taking prescribed medication (description below) at the Outdoor School in compliance with the program's policies and procedures.

Signature of Parent/Guardian ➔	Date	Home telephone number

MEDICATIONS: Description(s) of any and all medications shall be completed by child's physician. Please attach additional paperwork if necessary.

Name of medication	1.	2.	3.
Purpose of medication			
Dosage prescribed			
Time schedule			
Dose form (liquid, tablet)			

TO BE COMPLETED BY PHYSICIAN	Print Name of Physician	The above-named student, for whom the above medication is prescribed, is under my care.
	Phone/Address	**Signature of Physician** ➔
	City and zip code	Date signed (mo/day/yr)

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