Santa Cruz County Office of Education

Outdoor Science School

CONFIDENTIAL VISITING CLASSROOM TEACHER REGISTRATION FORM

Week Attending:_____ School:_____

Name:	School Telephone:
Home Address:	Home Telephone:
City: Zip:	Date of Birth:

Persons to contact in case of emergency:

1. Name:	Home Telephone:
Address:	Mobile Phone:
2. Name:	Home Telephone
Address:	Mobile Phone:

Please thoroughly answer the following questions:

1. Are you taking daily medication?_____ If yes, what medicine?_____
For what condition?_____
2. Do you take other medications at times?_____ If yes, what?_____
For what condition?_____
3. Do you have a health problem that could restrict your activities at Outdoor Science School (such as hypertension, arthritis, asthma, etc)?_____ If yes, please specify:_____
_____
4. Have you had a recent illness, surgery, broken bone or anything else we should know about?_____
If yes, please specify:_____
5. Do you have religious restrictions regarding medical aid?_____ If yes, please specify:_____
_____

Name of medical insurance company:_____Policy #_____

Physician's Name:_____ Telephone Number:_____
Address:_____ City:_____ Zip:_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT: I hereby authorize the Santa Cruz County Office of Education Outdoor Science School to provide medical or surgical care rendered through the facilities of the nearest hospital or doctor's office in any emergency which may occur during my participation in the Outdoor Science School program.

_____ _____

Date Signature

Rev 8/11