NATURE'S CLASSROOM STUDENT REGISTRATION

Please print all information, and please complete all the blanks.

Name _____ Date of Birth _____
(Last) (First)

Age _____ Sex _____ Weight _____ Height _____

Address _____
(Street and No.) (Town) (State) (Zip)

Parent's Name(s) _____

Home Telephone (_____) _____ Alternate Telephone (_____) _____

Family Physician _____ Telephone (____) _____

I give permission for (Name) _____ to attend Nature's Classroom for

the period of _____ as part of the outdoor education program of

(School Name) _____. I understand that the director of Nature's

Classroom may, if necessary for my child's health, have him/her hospitalized or use outside medical, surgical, or dental care. I also understand that the director and /or school leaders may dismiss my child from Nature's Classroom if, in their opinions, his/her conduct or influence is not in the best interest of the entire group. No refund is given if such action is taken for discipline reasons.

Date _____ **Signature** _____

Relationship _____

. . . . . .

MEDICAL PERMISSION SLIP

Should your child become ill, get a headache, catch a cold or have other minor medical or dental problems, do you give permission for the administration of basic first aid at the discretion of Nature's Classroom staff?

YES _____ **NO** _____

Date _____ **Signature** _____

Relationship _____

. . . . . .

If Ibuprofen or Tylenol needs to be administered, do you prefer:

IBUPROFEN _____ TYLENOL _____ OTHER (Specify) _____