

DOUGLAS COUNTY SCHOOL DISTRICT  
CLUB HEALTH FORM, Page 1

**STUDENT INFORMATION:**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parents/Guardians: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phones: \_\_\_\_\_

Work Phones: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

*The health information and medication information will be shared with school personnel and sponsor of the club as necessary to provide for your child's safety and well being.*

**HEALTH INFORMATION:**

Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child have: (circle & specify all that apply)

**Allergies?** NO YES

Specify: Bee/Wasp Stings Peanuts/Nuts Other \_\_\_\_\_

**Asthma?** NO YES

Specify: Inhaler Nebulizer Other \_\_\_\_\_

**Convulsions/Seizures?** NO YES

Specify: Type \_\_\_\_\_

**Diabetes?** NO YES

Specify: Insulin \_\_\_\_\_ Monitored Glucose Levels \_\_\_\_\_

**Dietary modifications: food allergies or intolerance (including milk)?** NO YES

Specify: Type \_\_\_\_\_

**Heart Problems?** NO YES

Specify: Type \_\_\_\_\_

**Other?** NO YES

Specify: Type \_\_\_\_\_

**Physical Limitations?** NO YES

Specify: Type \_\_\_\_\_ Special equipment? \_\_\_\_\_

YES

Specify: Type \_\_\_\_\_

Does your child take **any medications?** NO YES

Specify: Type \_\_\_\_\_

**\*\*\*\*\*Please note: ALL medications for club activities must comply with district medication policy. See overnight field trip medication information sheet for specifics. If your child has a condition that requires significant modifications during this activity, please contact your school nurse through your school's main office.**

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The School District does not have any medical/dental/hospitalization insurance-covering students for injuries incurred at school or while on club sponsored trips. If you have not already done so, you should obtain medical insurance coverage for your student. We do have insurance coverage related to the transportation of students, so long as they are passengers in District vehicles or in specially authorized private vehicles.

Insurance Company covering your student:

Policy number:

MEDICAL EMERGENCY/CONSENT FOR FIELD TRIP

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_, give my consent for emergency medical and surgical treatment in a licensed medical facility by a licensed physician should my student's condition require it in my absence. I understand that in such a case, reasonable attempts would first be made to contact me conditions and time permitting.

I confirm to the Douglas County School District Re. 1 that my student is in good health and that his/her participation does not pose a hazard to his/her health or that of participating students.

As long as the medical or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific prohibitions regarding treatment unless stated here: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## DCSD STUDENT PICK UP POLICY AND AGREEMENT

Parents are responsible for picking up their student within 15 minutes after the conclusion of his/her game or practice. There will be no supervision of students not picked up in compliance with this rule, and parents assume all responsibility for their student. Douglas County School District and Challenge to Excellence assumes no liability and has no responsibility for students not picked up within 15 minutes of the conclusion of the game or practice.

\_\_\_\_\_  
**Printed Name of Student**

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Student**

\_\_\_\_\_  
**Date**