ILAN RAMON DAY SCHOOL

To Whom It May Concern:

Our son/daughter _____, a student at Ilan Ramon Day School ***(27400 Canwood Street, Agoura CA 91301)*** has our permission to travel on the 4^{th} – 5^{th} grade class trip to Astro Camp in Idyllwild, CA, from Monday January 18 through Wednesday January 20, 2016. Several staff members from Ilan Ramon Day School are accompanying my child on this trip and they are authorized to administer medication or any necessary medical care in our absence.

In case of emergency, we can be reached at _____.
Emergency Phone Number

Our child has the following Medical Insurance:_____.
The subscriber number is:_____

Our Child's primary care physician is _____ and can be reached at _____***(Phone Number).***

Signed:_____
Parent / Guardian

Signed:_____
Parent / Guardian

Date: _____

ILAN RAMON
DAY SCHOOL

Ilan Ramon Day School
4th - 5th Grade Astro Camp Overnight
January 18 -20, 2016

Participant Name _____ **Date of Birth** _____

Address _____

City/State/Zip _____

Email Address _____

EMERGENCY CONTACTS – ***parent or legal guardian must be provided as first emergency contact***

#1. Name_____ Relation_____ Email_____

Employer _____ Day Phone _____

Evening Phone _____ Cell Phone/Pager _____

#2. Name_____ Relation_____ Email_____

Employer _____ Day Phone _____

Evening Phone _____ Cell Phone/Pager _____

HEALTH INFORMATION: PLEASE FILL OUT COMPLETELY ⁎DOCTOR SIGNATURE NOT REQUIRED⁎

Do you have, or have you had, any of the following conditions or symptoms?

Current Medical Conditions			**Diseases**		
1. Bleeding/Clotting Disorders	Yes	No	13. Chicken Pox	Yes	No
2. Asthma	Yes	No	14. Measles	Yes	No
3. Diabetes	Yes	No	15. Mumps	Yes	No
4. Ear Infections	Yes	No	16. Other Diseases	Yes	No
5. Heart Defects/Hypertension	Yes	No	**Allergies**		
6. Psychiatric Treatment	Yes	No	17. Hay Fever	Yes	No
7. Seizure Disorder	Yes	No	18. Iodine	Yes	No
8. Immunocompromised	Yes	No	19. Poison Oak	Yes	No
9. Sleep Walking	Yes	No	20. Poison Ivy / Sumac	Yes	No
10. Bedwetting	Yes	No	21. Penicillin	Yes	No
11. Other	Yes	No	22. Bees / Wasps / Insects	Yes	No
12. Hospitalized in the last 5 yrs?	Yes	No	23. Other	Yes	No

If participant Has Allergies/ Anaphalaxis / Asthma:

23. Do you carry your own Epi-Pen? Yes No

24. Do you carry your own Inhaler? Yes No

Date of last Tetanus Shot:
_____

If you have answered "yes" to any of the above items, please explain below. Provide corresponding number.
Question No. Explanation

Question No.	**Explanation**

Health Questionnaire: **(Attach additional pages if necessary to provide complete information.)**

Is the participant taking any medication? Yes No **Please list all medications** the participants is taking and the purpose of each.**

_____

_____

_____

_____

****Please continue to take all medications as prescribed unless otherwise instructed by your physician.**

Are there any restrictions on the participant's physical activity? Yes No
Please describe:

_____

_____

Does the participant eat **red meat**? Yes No **Poultry?** Yes No **Fish**? Yes No

Does the participant have any **food allergies**? Please specify _____

Does the participant have any **food restrictions**? Please specify_____

***** *Please note all food provided for the students on this overnight will be dairy / parve.***

Please provide any additional information that is important for us to know to insure the participant has a quality experience.

_____

_____

Name of Physician_____ Telephone Number _____

Medical Insurance carrier_____

Policy #/I.D.#_____ Subscriber Name_____

Additional information attached: Yes No
(please attach a photocopy of your child's medical insurance card)

AUTHORIZATION FOR TREATMENT: PARENT/GUARDIAN MUST SIGN
I agree the above information is correct to the best of my knowledge, and I authorize any representative of *Ilan Ramon Day School* or adult chaperone to consent to any X- ray, examination, anesthetic, diagnosis, treatment, and/or hospital care that may be recommended by a licensed physician and/or dentist. For minor illnesses or injuries, I understand that *Ilan Ramon Day School* will attempt to contact me at the earliest practicable opportunity. For major illnesses or injuries, *Ilan Ramon Day School* will attempt to contact me before the commencement of any medical treatment, unless my child's condition is such that treatment must be commenced immediately before contact with me can be made. Even if I cannot be reached, this authorization remains in full force and effect.

I hereby authorize a representative of *Ilan Ramon Day School* to dispense "over-the-counter" medication, including acetaminophen (Tylenol), ibuprofen (Advil/Motrin), Benadryl, Neosporin, Pepto-Bismol, Sudafed, etc., if needed, during the out-of-town trip with *Ilan Ramon Day School*.

I prefer, if the option exists, for the representative to give my child: acetaminophen ibuprofen

I agree to assume full financial responsibility for any medical care/treatment my child may receive.

Print Name of Parent/Guardian _____

Signature of Parent/Guardian_____ **Date:**_____

Print Name of Participant: _____

STUDENT HEALTH FORM

School: _____

Student Name: Last: _____ First: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian: _____ Cell Phone: _____ Work Phone: _____

Work Place: _____ Address: _____ City: _____ State: _____ Zip: _____

Height _____ Weight _____ Student Age: _____ Student Date of Birth: _____

Emergency Contact: _____

Address: _____

City: _____ State: _____

Phone: _____

Relationship to Student: _____

Health Insurance Co: _____

Policy No: _____

Phone: _____

Family Physician: _____ Phone: _____

Date of Last Tetanus: _____

IMPORTANT: A signature at the bottom of this form by a parent or legal guardian is required for participation at AstroCamp.

EMERGENCY MEDICAL CONSENT: The Student's medical conditions and information stated on this application is complete and correct. I give permission to the AstroCamp camp staff and School chaperones to, (1) administer the Student's routine medications listed in this Application, as well as needed medications and over-the-counter medications for minor illness or discomfort; (2) in case of a medical emergency to provide appropriate first aid for minor injuries; and (3) seek further treatment from local physicians or hospitals if the medical condition warrants. In the event I cannot be reached in an emergency, I also give permission to the physician selected by AstroCamp or the School chaperone to examine, diagnose, and treat or secure proper treatment for the Student and hospitalize, and to order injection and/or anesthesia and/or surgery for the Student, as the physician shall determine proper and necessary under the circumstances. A photocopy of this Authorization shall be as valid and may be accepted as the original. This completed Application may be photocopied by AstroCamp and released to the physicians or hospitals if requested. This Consent is given pursuant to the provisions of California Family Code §6910.

CONSENT AND RELEASE OF LIABILITY: I have been informed of the nature of the AstroCamp program in which the Student is enrolling. I understand that there are risks associated with the Student's participation in camp programs and activities and transportation to and from camp, which can pose a threat of injury or illness. I am familiar with outdoor sports and activities and the Student's abilities and I am not aware of any physical, emotional, or mental problem or limitation that would prevent, impair, or increase the risk of harm involved in the Student's participation in AstroCamp camp activities. I also recognize that AstroCamp cannot ensure or guarantee that the participants, equipment, grounds and/or activities will be free of accidents or injuries. I am aware and have or will instruct the Student in the importance of knowing and abiding by the AstroCamp camp rules and regulations. I agree to direct the Student to comply with all AstroCamp rules and policies, and to cooperate with AstroCamp personnel. I understand and agree that if the Student fails to comply with AstroCamp rules or policies, he or she may be expelled from camp and sent home at my, the parent or legal guardian's, expense.

With this knowledge and understanding, I grant permission for the Student to participate in all AstroCamp camp activities and on behalf of the undersigned and the Student, I accept and assume the risk and full responsibility for injury and illness or loss of personal property or other damage, and medical or other expense that may result from the Student's presence or participation in the activities at AstroCamp camp.

I hereby release and discharge Guided Discoveries, Inc., AstroCamp, and their agents and employees from liability to us and to the Student for any and all loss, damage, and expense and any illness or injury to person or property, resulting from the Student's travel to or from AstroCamp and participation in the camp activities and programs.

I give permission for AstroCamp to use any photographs, video, or interview taken at camp to be used to illustrate, report, promote or advertise AstroCamp or Guided Discoveries programs or camps.

SIGNATURE: _____

Parent/Legal Guardian

Please Print Name: _____ **Date:** _____

Rules for acceptance and participation in Guided Discoveries, Inc. programs are the same for everyone without regard to race, color, national origin, sex, or handicap.

DIETARY NEEDS:

Vegetarian___ Vegan___ Lactose-Intolerant___ Gluten-Free___ Other___

FOOD ALLERGIES: Please Describe:

CHECK OFF: All applicable health issues:

___ Allergies*	___ Allergy – Bee Sting*
___ Asthma	___ Backaches/Weak Back
___ Car/Sea Sick	___ Bowel/Bladder Problems
___ Diabetes	___ Epilepsy/Convulsive Disorder
___ Hay Fever	___ Headache
___ Heart Trouble	___ Poison Oak
___ Sinus Issues	___ Respiratory Problems**
___ Sleep Walking	___ Vomiting

*Has your child been prescribed an EpiPen for allergies? YES___NO___. **If YES, the EpiPen must accompany your child to camp in order to participate in activities.**

Does your child require an inhaler(s) on a daily basis and/or for exercise-induced activities? YES ___ NO___. **If YES, the inhaler(s) must accompany your child to camp in order to participate in activities.

Please specify with YES or NO for each medication that can be administered to your child.

_____ Pepto Bismol (upset stomach)
_____ Milk of Magnesia (for constipation)
_____ Ibuprofen (minor aches pains; fever)
_____ Throat Lozenge/Cough Drop
_____ Benadryl (allergy)
_____ Caladryl (for skin rash)
_____ Aceteminophen (headaches/elevated temperatures)
_____ Bonine/Meclazine/Dramamine (motion sickness)

Is the student required to take regular medication?

YES _____ NO _____

☆ All medications are administered by the chaperones from the student's school. Please provide instructions (dose) for administration of medication.

WHAT IMPORTANT MEDICAL NEEDS SHOULD ASTROCAMP BE AWARE OF? PLEASE EXPLAIN IN DETAIL.

(Attach additional sheet if necessary.)

ASTROCAMP STORE PREORDER FORM

School Name: Ilan Ramon Day School Trip Dates: 1/18/16 -1/20/16

If you would like to preorder items, please fill out this Preorder Form with the quantity/size of sweatshirts and t-shirts for your school. *Your **deadline** is listed in the **Planning Packet Email.***

Payment is due upon arrival to AstroCamp. Please write **ONE** check payable to AstroCamp, and include your school's name somewhere on it.

Send Preorder Form to:

Fax/Email:
Secretary@astrocamp.org
Fax: 951-659-9843

-OR-

Mail to:
Astrocamp c/o Cathy Regalado
P.O. Box 3399
Idyllwild, CA 92549

All clothing comes in Adult Sizes

Hooded Sweatshirts ($30)		
Size	**Quantity**	**Total $**
Small		
Medium		
Large		
X-Large		
XX-Large ($32 per item)		
Short Sleeve T-Shirts ($15)		
Small		
Medium		
Large		
X-Large		
XX-Large ($17 per item)		
	GRAND TOTAL:	

Your preorder will be delivered to your dorm by dinner on Arrival Day.

We can ship your preorder to your via UPS (please call for shipping & handling fees).

AVAILABE FOR PURCHASE AT ASTROCAMP*

Note: Parents may send cash or checks with their children payable to AstroCamp for in-store purchase. If a check amount exceeds the amount spent on store purchases, we will give a cash refund.

Hooded Sweatshirts	$	30.00	Carabiners	$	4.00
PJ Bottoms	$	22.00	Astronaut Ice Cream	$	4.00
T-shirts	$	15.00	Plastic Water Bottles	$	3.00
Glowing Astro Frisbees	$	15.00	Chapstick	$	2.00
Baseball/Stocking Hats	$	12.00	Post cards	$	1.00
Glowing Nalgene Bottles	$	12.00	Gatorade	$	1.00
Beanie Critters	$	8.00	Bottled Water	$	1.00
Magnetic Rocks	$	6.00	Pencils	$	0.50

*Products and prices are subject to change