



MEDIA PERMISSION SLIP

Childs Name: _____

I give permission and consent for _____ to allow photographs to be taken during DeVries Nature Conservancy activities. I further give permission and consent that any such photographs my be published and used by DeVries Nature Conservancy to illustrate and promote its programs.

Signed (Parent or Guardian): _____

HEALTH HISTORY FORM

Allergies: (list all known)

Medication: _____

Food: _____

Other (insect stings, asthma, animals, grass, etc.): _____

Has your child:

Had a recent injury of illness? ___ No ___ Yes _____

Chronic illness/condition? ___ No ___ Yes _____

Have skin problems? ___ No ___ Yes _____

Wear glasses or contacts? ___ No ___ Yes _____

Have seizures? ___ No ___ Yes _____

Have diabetes? ___ No ___ Yes _____

Other? _____

Medications Needed:

Medication	Dosage	Hours Given	Reason

I hereby give permission to administer the over-the-counter medications listed below, or their generic equivalents EXCEPT THOSE I HAVE CROSSED OUT if the education staff deem it necessary, or I have provided them. Dosages will be administered according to the directions on the bottle unless a physician directs otherwise:

- | | | | |
|----------------------|-------------|------------|-----------------|
| Benadryl | Cough drops | Tums | Pepto Bismol |
| Hydrocortisone cream | Eye drops | Aloe Cream | Caladryl lotion |

I certify that my child is healthy, with up-to-date immunizations.

Parent or Guardian signature: _____ Date: _____