OFFICE USE ONLY
CAMP _____
WEEK _____

MEDICAL NEEDS FORM: Complete this form if you have students with a physical or medical need such as a chronic/serious illness (diabetes, epilepsy, etc...), student with speech/hearing impairment or a student who requires the use of a wheelchair or adaptive devices. Return it to the Outdoor School office **as soon as possible** to allow for special planning. Include **SEVERE dietary restrictions and/or allergies**. **If you need additional forms, please make copies.**

Teacher's name _____   School _____

School Phone #_____   Teacher E-Mail: _____

Student's Name _____

Life threatening Allergy: Yes ☐   No ☐

Carries an EPI pen: Yes ☐   No ☐

Is student on a 504 Plan: Yes ☐   No ☐

Uses a wheelchair or Adaptive Device?   Yes ☐ No ☐

Attending with an Aide?   Yes ☐   No ☐

Requires bathroom aide (toileting & showering):   Yes ☐ No ☐

Student Need: _____

_____

_____

_____

_____

Special Education teacher or other individual who may have additional information:

Name: _____   Email:_____   Phone: _____

Student's Name _____

Life threatening Allergy: Yes ☐   No ☐

Carries an EPI pen: Yes ☐   No ☐

Is student on a 504 Plan: Yes ☐   No ☐

Uses a wheelchair or Adaptive Device?   Yes ☐ No ☐

Attending with an Aide?   Yes ☐   No ☐

Requires bathroom aide (toileting & showering):   Yes ☐ No ☐

Student Need: _____

_____

_____

_____

_____

Special Education teacher or other individual who may have additional information:

Name: _____   Email:_____   Phone: _____