



# Medical and Release Form

Earthroots requires a current Medical and Release Form for each person attending any class and/or event. Send an updated form if any info changes. Please print clearly (in blue or black ink) and sign the second page in two separate places. Mail completed form to: Earthroots Field School • P.O. Box 504 • Trabuco Canyon, CA 92678

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Gender (circle): Male Female Prefer not to say Prefer to self-describe \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ E-mail: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone - Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
Out-of-State Contact (Name and Phone): \_\_\_\_\_

### Medical Conditions (\*\*CONFIDENTIAL\*\*)

So that we can properly assist you, it is your responsibility to make Earthroots Field School aware of any medical conditions below and at registration. Please attach additional pages as needed.

- | <u>Do you/your child:</u>   | <u>No</u>                | <u>Yes</u>               |   | <u>No</u>                | <u>Yes</u>               |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| • Wear contact lenses/glasses? .....  | <input type="checkbox"/> | <input type="checkbox"/> | • Have an allergic reaction to:                                     |                          |                          |
| • Wear a hearing aid? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 1. Medications? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have asthma? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 2. Insect bites or stings? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have any physical disabilities? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 3. Foods? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have any special needs that may affect your participation in the program? (e.g., fears, second language, ADD, etc.) ..... | <input type="checkbox"/> | <input type="checkbox"/> | 4. Plants? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have any other condition that may endanger, alter, or somehow limit your ability to participate in the program? .....     | <input type="checkbox"/> | <input type="checkbox"/> | 5. Other? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | • Take any medication currently? .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | • Use medication for allergic reactions? .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | • Have special dietary needs? (e.g., Vegetarian, Vegan, etc.) ..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain in detail any "Yes" answer marked above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\* Note: if you have anaphylactic allergic reactions we request that you bring EpiPen or AnaKit \*\***

### Insurance Information (if you do not carry health insurance, please note)

Name of Health Insurance Carrier: \_\_\_\_\_  
Group/Plan Number: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of last tetanus booster: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Photo Release:** By signing at the bottom of this form I hereby grant free permission for Earthroots Field School to use images of me participating in their programs or events for outreach purposes, including but not limited to electronic or print materials or media.

[ ] **No, I do not wish to grant a photo release.** (Please consider granting this release to us if at all possible, as our ability to successfully share our programs with new participants depends on having representative photographs.)

**Medical Release:** In the event that I require medical attention while participating in this program, I hereby grant permission to Earthroots Field School and its representatives to provide for the rendering of such care, including diagnostic procedures, surgical and medical treatment, by authorized medical staff or their designees, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment. I acknowledge that I am responsible for all reasonable expenses in connection with care and treatment rendered during this period.

