### STUDENT MEDICAL FORM

PLEASE PRINT CLEARLY						
I/We, the parent(s) or guardian(s) of the participant named belo Ocean Institute's <u>Catalina Odyssey–A Voyage of Discovery</u> Pro						
Dates attending: to: Birth o	date:/					
Participant's Name (Last):	(First):					
Address:	City:					
State: Zip: Home Phone: ()	Cell Phone: ()					
In case of emergency, please notify: Parent(s)/Guardian(s) Nar	me:					
Address:	City:					
State: Zip: Home Phone: ()	Cell Phone: ()					
*Business Number: () *Employer: _						
Alternate Person in case of emergency, please notify:						
Name/Phone number of Family Physician:						
Name/Number of family medical insurance carrier:						
PARTICIPANT HEALTH INFORMATION						
Does the participant have any physical or medical condition	ns or restrictions? Yes No					
f so, please describe:						
If your child has a special medical or physical condition, your physician should understand that the participant will be away from home for two full days. Please have your physician write a note indicating agreement that the participant is fit enough to fully participate in the program and to also include any special instructions.						
2. Is your child subject to any of the following? Please circle:						
Homesickness Sleepwalking Bed wetting (send extra	ra bedding) Car/motion sickness					
B. Does your child have any dietary requirements or restriction	ns? Yes No_					
f so, please describe:						
Does your child have any allergies that may be of concern? Yes No_						
f so, please describe the severity of the allergy:						
6. Has the participant recently been ill or exposed to any comm	municable diseases? Yes No					

Ocean Institute	Required Forms	Catalina Odyssey–A Voyage of Discovery
If so, please explain:		
MEDICATION		
Discovery program, an <i>ADMINISTRAT</i> guardian and your child's physician. For medication prescribed for the period you be clearly labeled with the following information as Participant's full name.	TION OF MEDICATION or prescription medication our child will attend the promation:	uring the Catalina Odyssey–A Voyage of form must be completed by a parent or on, a form must be completed for each rogram. The prescription container must c. Physician's phone number f. Expiration date of Rx.
Each medication must be in a separate		
stomach remedies) during the program completed by a parent or guardian and	, an ADMINISTRATION your child's physician. ontainer and clearly labe tion medication unless	Any non-prescription medication you send eled with your child's name. No child will this form is completed, with a
		dition, your physician should understand structions should be attached to this form.
AUTHORIZATION AND CONSENT FO	R PARTICIPANT TRE	ATMENT
<ol> <li>Parents will be notified immediately according to the parent's wishes. Arrar desired.</li> </ol>		injured or seriously ill, and aid will be with the parent(s) to pick up their child if
2. A child will not be released during t written or verbal request by the parent of		ther than parent or guardian except on
and is to be rendered under the genera under the provisions of the California M hospital, whether such diagnosis or trea	is or treatment and hos l or special supervision edical or Dental Practica atment is rendered at off	pital care which is deemed advisable by, of any physician and/or surgeon licensed es Act on the medical staff of a licensed
care being required but is given to provi specific consent to any and all such dia physician in the exercise of his best jud to the provisions of Section 25.8 of Civil	ide authority and power gnosis, treatment, or ho gment many deem advi l Code of California. Th	on the part of aforesaid agents to give
Signature of Adult Participant or Parent	/Legal Guardian of Child	Date
If it is desired that no medical treatm instruction and sign here.	ent be given to the par	ticipant please provide the necessary
Signature of Adult Participant or Parent	Legal Guardian of Child	Date

## **ADMINISTRATION OF MEDICATION, PAGE 1**

Name of Participant:					
Dates Attending:					
The nature of the program requires that all children participate in a variety of learning and social activities involving vigorous activities and walking. Standardized, well-balanced meals are provided.					
It is understood that the Ocean Institute is not legally obligated to administer medication to my/our child, and therefore, I/we agree to hold the Ocean Institute and its personnel free from any and all responsibility for the results of such medication, or the manner in which it is administered and to indemnify each of them against the loss of reason of any civil judgment arising out of these arrangements which may be rendered against them.					
INSTRUCTIONS  No one is to administer medication to any child without authorization of the parent(s) or guardian(s). If you wish your child to receive medication you must fill out Part I: Prescription Medication and/or Part II: Non-Prescription Medication. These forms will be kept with the medication. A parent/ guardian and physician's signature is required for each of these sections.					
Part I: Prescription Medication					
MEDICATION 1					
Diagnosis:	Date of Examination:				
Medication Prescribed:	Dosage:				
Schedule and Method of Administration:					
Comments:					
Physician's Signature:					
Parent(s)/Guardian(s) Signature:					
MEDICATION 2					
Diagnosis:	Date of Examination:				
Medication Prescribed:	Dosage:				
Schedule and Method of Administration:					
Comments:					
Physician's Signature:					
Parent(s)/Guardian(s) Signature:					

# ADMINISTRATION OF MEDICATION, PAGE 2

Name of Participant:		
Dates Attending:		
Part II: Non-Prescription Medication		
MEDICATION 1		
Medication:	Dosage:	
Schedule and Method of Administration:		
Comments:		
Physician's Signature:		
Parent(s)/Guardian(s) Signature:		
MEDICATION 2		
Medication:	Dosage:	
Schedule and Method of Administration:		
Comments:		
Physician's Signature:		
Parent(s)/Guardian(s) Signature:		
MEDICATION 3		
Medication:	Dosage:	
Schedule and Method of Administration:		
Comments:		
Physician's Signature:		
Parent(s)/Guardian(s) Signature:		

#### ACKNOWLEDGEMENT OF RISK AND WAIVER FOR ALL PARTICIPANTS

Welcome to the Ocean Institute! We want you and everyone to have a memorable and safe experience.

The Ocean Institute's environment, vessels, facilities, and activities are unique and different from your usual surroundings and activities. There are many inherent risks, dangers, and hazards and everyone must exercise caution at all times in order to avoid or minimize the risk of damage, injury and death.

Examples of these risks, dangers, and hazards include, without limitation: (a) walking and standing surfaces that may be wet, slippery, moving, irregular, unstable, and rough; (b) open areas such as hatches into which someone could fall; (c) low or irregular lighting, or no lighting at all; (d) objects and equipment that could fall on someone; (e) low ceilings; (f) ropes, chains, and other items that could strike or entangle someone; (g) extreme and variable physical, weather, and ocean conditions, including darkness, sun glare, storms, and hot and cold temperatures; (h) vessels, docks, buildings, ladders, and stairs from which someone could fall; (i) vessels and docks that could pitch, roll, capsize, flood, collide, and sink; (j) gaps between a vessel and a dock that could open or close suddenly and unpredictably; (k) possible encounters with wildlife and plants; and (l) unavailability of medical attention and treatment.

If you attend Ocean Institute activities, then you must exercise caution at all times to protect yourself and others from these risks, dangers and hazards. If children or other persons under your care attend any Ocean Institute activities, then discuss these risks, dangers, and hazards with them as they too must exercise caution at all times.

Program Name: Catalina Odyssey-	-A Voyage of Discover	y F	Program D	ate:
Participant Name: Last:		First:		
Birth date:	<u>.</u>			
Guardian Name: Last:		First:		
Home Phone:	Cell Phone:	Work	Phone:	
Address:				
City:		State:	Zi	p:
Email:				
If you attend any Ocean Institute activit by checking the box below you, on beh understood this document and to have directors, officers, employees, contract death occurring during or by reason of	alf of yourself and such o irrevocably waived any a ors, volunteers, agents, a	ther persons, shall nd all claims again	be deemed st the Ocea	d to have read and in Institute and its
Additionally, I authorize the use of phot Institute for its promotional purposes.	os and/or video footage t	aken of me and oth	ners under r	ny care by the Ocean
Parent/Guardian Signature:				4
Today's Date:				NINSTITUTE