2024 Registration Form
Cordillera Equestrian Center Summer Horse Camp

Welcome to the Cordillera Equestrian Center (CEC) Summer Horse Camp! We are excited to share our passion and knowledge of horses with young riders.

Each camp day will include riding as well as other aspects of horsemanship including safety awareness, catching, leading, grooming, horse health, horse behavior, groundwork, and games.

IMPORTANT: Horse Camp is open to riders ages 7–15. Please fill out one registration form per camper (rider).

Contact Information:

Name of rider: _____Age of rider: _____DOB: _____

Parent / Guardian name: _____ Phone: _____

Parent / Guardian name: _____ Phone: _____

Email Address: _____

Address: _____City: _____

State: _____ZIP code: _____

Registering for these camp dates (check all that apply):

- ☐ June 11 – June 14
- ☐ June 18 – June 21
- ☐ June 25 – June 28
- ☐ July 9 – July 12
- ☐ July 16 – July 19
- ☐ July 23 – July 26
- ☐ July 30 – Aug. 2
- ☐ Aug. 6 – Aug. 9

Rider's experience level:

- ☐ **Beginner**: No previous experience, can safely control a horse at a walk
- ☐ **Advanced beginner**: Can safely control a horse at a walk/trot
- ☐ **Intermediate**: Can safely control a horse at a walk/trot, has begun to canter
- ☐ **Advanced**: Can safely control a horse at all gaits, walk/trot/canter

Camper Name: _____

Primary type of riding interest:

☐ English

☐ Western

T-Shirt Size: Child size XS☐, S☐, M☐, L☐ | Adult S☐, M☐, L☐, XL☐

How did you hear about the Cordillera Horse Camp? (check all that apply)

☐ Previously attended Cordillera Equestrian Center Horse Camp
☐ Property Owner
☐ Club at Cordillera member
☐ Cordillera Connection newsletter
☐ CordilleraLiving.com website
☐ Facebook
☐ Friend or family member
☐ Other_____

CEC Horse Camp Program Rules

1. Proper riding attire is required. This includes boots with heels, an ASTM/SEI-certified horseback riding helmet, and long pants. CEC helmets are available to borrow on a limited basis. If you have questions about equipment, we're happy to advise. Email Equestrian Center Manager Annie Morris prior to camp: amorris@cordilleraametro.org.
2. If unable to borrow an ASTM/SEI-certified horseback riding helmet, campers will need to purchase one by the first day of camp.
3. All students MUST WEAR A HELMET WHEN RIDING OR ON THE GROUND AROUND HORSES.
4. Drinks must be in a plastic bottle; no glass bottles at the facility.
5. Do not touch or feed any horse without your instructor's consent.
6. Do not enter any stall or paddock without your instructor present.
7. Do not run up to or walk closely behind a horse. Keep at least 15 feet back to avoid potential injury.
8. No dogs or other pets allowed at the barn.
9. Parents / Guardians are responsible for children who are on the property and not in camp. To avoid potential accidents, no loose or unattended small children are allowed.
10. Upon registration, all paperwork including a liability waiver must be filled out and submitted. Health forms are due before the first day of camp.
11. Please make sure children are prepared to focus, listen, and learn. Horses are large animals that can unintentionally cause great harm. **Safety is the priority.** If an individual is unable to listen and follow instructions, then they are not ready for camp and will be sent home.

Camper Name: _____

Required Equipment

- ASTM/SEI-certified horseback riding helmet.
- English or Western style boots. Must have a heel. **No tennis shoes.**
- Riding pants, leggings, or running tights. Jeans are acceptable. **No shorts.**
- Long or short-sleeve shirt. **No tank tops.**
- Please send a sack lunch, snacks, a plastic water bottle, and sunscreen with your camper(s) each day.

Cost

$900 per week. Payment of $900 is due at the time of registration.

Cancellation Policy

When we reserve your space for the summer, we oftentimes turn other families away and are unable to fill that space later. Therefore, there are no daily cancellations or changes. If canceling for the week, $100 of the $900 payment per program is non-refundable and non-transferable.

Cancellation Deadlines for 2024

On or before 5/14/24: Forfeit $100 per week of camp registered for. Cancellation must be made for exact schedule chosen. We cannot accept any switches for other days or weeks. Cancellations must be made in writing and emailed to: info@cordilleraметro.org.

After 5/14/24: No refunds or changes available. By signing below, I agree to the cancellation policy above.

_____

Parent / Guardian Printed Name

_____ _____

Parent / Guardian Signature Date

Camper Name: _____

2024 Horse Camp Registration Forms Checklist

Included with this Cordillera Equestrian Center Summer Horse Camp Registration Packet are the following items. Return all items including this page by email to: forms@cordilleraMetro.org. Registration packet items can also be mailed or brought to the **Cordillera Metro District Admin Office, Attn: Horse Camp, 408 Carterville Road, Edwards, CO 81632**.

One form per child serves all camp sessions you are registering for. Original signatures are required.

Initial below to confirm:

DUE AT TIME OF REGISTRATION:

_____ Payment of $900 per camp week.

_____ I have received, read, and filled out the **Cordillera Equestrian Center Summer Horse Camp Registration Form** with accurate information.

_____ I have received, read, and signed the **Emergency Contact, Health Waiver, and Release**.

_____ I have received, read, and signed the **Horse Camp Waiver & Release.**

_____ I have received, read, and signed the **Authorization to Pick Up / Drop Off a Child.**

_____ I have received, read, and signed the **Educational Media and Photography Permission.**

_____ I have received, read, and understand the information in the **Cordillera Horse Camp Parent Handbook**.

DUE BEFORE FIRST DAY OF CAMP:

I understand that I need to submit the following items, or the registered camper will not be allowed to attend camp. **The following forms need to be signed by a medical professional.**

_____ I have received, read, and filled out the **Colorado Certificate of Immunization**.

_____ I have received, read, and filled out the **Universal Child Health Record**.

IF APPLICABLE:

_____ I have received, read, and signed the **Medication Administration Permission.**

PLEASE SIGN BELOW:

_____

Parent / Guardian Printed Name

_____ _____

Parent / Guardian Signature Date

CORDILLERA
Equestrian Center

2024 Horse Camp

Emergency Contact, Health Waiver, and Release

_____ _____

NAME OF PARTICIPANT AGE (on the first day of camp)

_____

ADDRESS CITY STATE ZIP

Our primary means of communication with you is through email. Please provide all email addresses where you'd like to receive notifications:

_____

_____

I have read, understand, and will abide by the CEC Horse Camp Program Rules.

_____ _____

Parent / Guardian Signature Participant / Camper Signature

CONTACTS FOR EMERGENCIES & CAMP CANCELLATIONS:

Persons listed must be reachable during camp hours. List contacts in order of whom to contact first.

1. _____

NAME PHONE RELATIONSHIP TO CHILD

2. _____

NAME PHONE RELATIONSHIP TO CHILD

3. _____

NAME PHONE RELATIONSHIP TO CHILD

Camper Name: _____

MEDICAL INFORMATION & SPECIAL CONSIDERATIONS

Check any that apply to your child. With awareness of your child's needs, staff may be able to modify activities and techniques for inclusiveness prior to the start of the camp.

☐ No specific medical or behavioral condition

☐ Food allergies – please specify: _____

☐ Non-food allergies – please specify: _____

☐ Please specify any physical, emotional, or behavioral conditions, including cognitive, LD, ADD, ADHD, or autism requiring medication, treatment, special restrictions, or considerations while at camp: _____

_____

List triggers, signs, or symptoms for these conditions:

_____

_____

Techniques you recommend in managing your child's behavior:

_____

_____

List activities from which the camper should be exempted for health reasons or require special accommodations:

_____

MEDICATIONS: List below all medications taken regularly, including EpiPen, asthma inhaler, over the counter, or nonprescription drugs. *If your child needs to take medication or you expect camp staff to dispense medication to your child <u>during camp hours</u>, you must also complete the Medication Administration Permission form. Please note that it is your responsibility to supply any necessary medical equipment that relates to a specific medical condition.*

MEDICATION	DOSAGE	SPECIFIC TIME TAKEN	REASON FOR TAKING
MEDICATION	DOSAGE	SPECIFIC TIME TAKEN	REASON FOR TAKING

Camper Name: _____

HEALTH INSURANCE & PHYSICIAN INFORMATION

Insurance Company: _____

Policy / Group Number: _____

Participant ID Number: _____

Physician's Name: _____ Office phone number: _____

Past Medical Treatment: Please list any major medical treatment within the last year:

Notification: When DO you want to be notified for *minor* injuries (e.g., scrape, non-allergic bee sting, bloody nose, sliver) that do not limit participation? ☐ immediately ☐ at camper pick up

PERMISSION TO SECURE TREATMENT

Camp staff are certified in First Aid, CPR, AED, EpiPen, and asthma inhaler assistance. They will take whatever emergency medical measures are deemed necessary for the protection and safety of the camper within their training.

In the event of any emergency, I authorize the Eagle River Fire Protection District / Eagle County Ambulance District to secure from any licensed hospital, physician and/or medical personnel any treatment deemed necessary for me or my minor child/ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered. I understand that this authorization includes transporting my child by ambulance if necessary to the nearest medical treatment facility if I am unable to be reached first.

_____
Parent / Guardian Printed Name

_____ _____
Parent/Guardian Signature Date

2024 Horse Camp
Waiver & Release

_____ Birthdate: _____ Grade entering: _____
NAME OF PARTICIPANT (mm/dd/yyyy)

Please read this form carefully, and be aware that in registering your minor child/ward for participation in Cordillera Equestrian Center Horse Camp ("Horse Camp"), you will be waiving and releasing all claims for injuries you or your minor child/ward might sustain arising from Horse Camp.

Important Information

The Cordillera Metropolitan District (the "District") is committed to conducting its programs and activities including Horse Camp in the safest manner possible and holds the safety of participants in the highest possible regard. Participants and parents registering their children in Horse Camp must recognize, however, that there is an inherent risk of injury when choosing to participate. The District strives to reduce such risks and insists that all participants follow safety rules and instructions which have been designed to protect the participant's safety.

Please recognize that the District does not carry medical accident insurance for injuries sustained in its programs and activities including Horse Camp. The cost of such medical expense would make program fees prohibitive. Therefore, each person registering themselves or a family member for a program or activity should review their own health insurance policy for coverage. It must be noted that the absence of health insurance coverage does not make the District automatically responsible for the payment of medical expenses. Your cooperation is greatly appreciated.

Release of Liability & Permission to Secure Treatment

I recognize and acknowledge that there are certain risks of physical injury to Horse Camp participants, and I agree to assume the full risk of any injuries, damages, or loss regardless of severity which I or my minor child/ward may sustain as a result of participating in any and all activities connected with or associated with Horse Camp.

I agree to waive and relinquish all claims I or my minor child/ward may have against the District and its officers, directors, agents, volunteers, and employees as a result of participation in Horse Camp.

I do hereby fully release and discharge the District and its officers, directors, agents, volunteers, and employees from any and all claims from injury, damage, or loss associated with the activities of Horse Camp.

I further agree to indemnify, assume all responsibility for, hold harmless, and forever defend the District and its officers, directors, agents, servants, and employees from and against any and all claims that are related to, arise out of, or are in any way connected with my or my minor child's participation in Horse Camp including, but not limited to, claims of negligence or acts of omissions, or some other cause of any kind or nature, whether foreseen or unforeseen, resulting in any damage, loss, injury, paralysis, or death to me or my minor child or my property from engaging in Horse Camp.

I, for myself, my legal representatives, my heirs, successors, executors, and subrogees, further agree not to sue the District and its directors, officers, employees, servants, and authorized volunteers, as a result of any injury, paralysis,

or death suffered in connection with my or my minor child's participation in Horse Camp on property owned by the District. I further agree that, in any legal action brought to enforce this waiver, the prevailing party shall be entitled to recover expenses relating thereto, including attorneys' fees.

In the event of any emergency, I authorize the District to secure from any licensed hospital, physician, and/or medical personnel any treatment deemed necessary for me or my minor child/ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered.

I HEREBY REPRESENT THAT MY MINOR CHILD/WARD IS IN GOOD HEALTH, THAT THERE ARE NO SPECIAL PROBLEMS ASSOCIATED WITH THE CARE OF THE MINOR, AND THAT I HAVE ADEQUATELY INFORMED THE DISTRICT'S PERSONNEL OF ANY SPECIAL INSTRUCTIONS REGARDING MY MINOR CHILD.

WARNING

Under Colorado Law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Section 13-21-119, Colorado Revised Statutes.

BY MY SIGNATURE BELOW, I HEREBY CLAIM THAT I HAVE CAREFULLY READ, CLEARLY UNDERSTAND, AND VOLUNTARILY SIGN THIS ACKNOWLEDGEMENT, WAIVER, AND RELEASE FROM LIABILITY, AND AM VOLUNTARILY GIVING UP SUBSTANTIAL LEGAL RIGHTS INCLUDING THE RIGHT TO SUE, AND THAT I VOLUNTARILY SIGN THIS ACKNOWLEDGEMENT, WAIVER, AND RELEASE FROM LIABILITY.

_____
Parent / Guardian Printed Name

_____ _____
Parent / Guardian Signature Date

CORDILLERA
Equestrian Center

2024 Horse Camp
Authorization to Pick Up / Drop Off a Child

Camper: _____

I hereby inform Cordillera Horse Camp that the people listed below are authorized to pick up the above named camper.

AUTHORIZED PICK-UP PERSONS:
Must be a minimum of 18 years old unless special written arrangements are made.

Approved name:	Relationship to camper:	Phone Number:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

UNAUTHORIZED PICK-UP PERSONS (if applicable):

Name:	Relationship to camper:
1._____	_____
2._____	_____
3._____	_____

I understand that:

- Any person that picks up child/ren will be asked to provide a photo ID if staff are not familiar with the person on the above list.
- Prior written notification by email to info@cordillerametro.org must be given to the camp by parent/guardian if you wish to add a person to your authorized pickup list.
- This document shall remain valid until edited or rescinded in writing by the parent/guardian.

Authorized by:

_____
Parent / Guardian Printed Name

_____ _____
Parent / Guardian Signature Date

2024 Horse Camp
Educational Media and Photography Permission

EDUCATIONAL MEDIA PERMISSION

The Horse Camp curriculum may include viewing equestrian educational materials in a variety of formats.

_____ I DO

_____ I do NOT

give my permission for _____ to view horse-related educational content rated G or PG at
(Camper Name)

Cordillera Equestrian Center Horse Camp.

Authorized by:

_____
Parent / Guardian Printed Name

_____ _____
Parent / Guardian Signature Date

PHOTOGRAPHY RELEASE

_____ I DO

_____ I do NOT

give my permission for photographs of the above-named camper to be used by the Cordillera Metro District.

Authorized by:

_____
Parent / Guardian Printed Name

_____ _____
Parent / Guardian Signature Date

COLORADO CERTIFICATE OF IMMUNIZATION

cdphe.colorado.gov/immunization

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician [MD, DO], advanced practice nurse [APN] or delegated physician's assistant [PA]) or school health authority. School-required immunizations follow the Advisory Committee on Immunization Practices (ACIP) schedule. If the student provides an immunization record in any other format apart from this Certificate or an Approved Alternate Certificate (details found at cdphe.colorado.gov/immunization/forms), the school health authority must transcribe the record onto this form. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at sixth grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian:(if student is under 18 years of age and not emancipated) _____

Required Vaccines

	Immunization date(s) MM/DD/YY						**Titer Date*** MM/DD/YY
HepB Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)†							
Tdap Tetanus, Diphtheria, Pertussis†							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella ‡							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** - positive screen date	

*The shaded area under "Titer Date" indicates that a titer is not acceptable proof of immunity for this vaccine.

In several instances, laboratory confirmation of positive titers are an acceptable alternative to written documentation of vaccination. A positive laboratory titer report must be provided to the school to document immunity. More information on titers can be found within the Colorado Board of Health rule 6 CCR 1009-2.
† For DTaP and Tdap, both the diphtheria and tetanus titers must be positive. A titer is never acceptable to demonstrate immunity to pertussis.
‡ Laboratory confirmation of positive titers are an acceptable alternative to the MMR vaccine only when titers for all three components (measles, mumps, and rubella) are positive.

Recommended Vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
RV Rotavirus							
MCV4 Meningococcal							
MenB Meningococcal							
HepA Hepatitis A							
Flu Influenza							
COVID-19							
Other							

Health care provider printed name/signature: _____ / _____ Date: _____

Student is current on required immunizations for age (circle one): OR Yes No
Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Last Reviewed: May 2023

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Cordillera Equestrian District Horse Camp Medication Administration Permission

The parent/guardian of _____ ask that **Horse Camp** staff give the
(Child's name)
following medication _____ at _____
(Name of medicine and dosage) (Time(s))
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

Horse Camp staff agree to administer medication prescribed by a licensed health care provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff. All medication(s) that are left at the camp will be discarded according to the most current state regulatory recommendations for safe medication disposal.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the camp staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

****

Health Care Provider Authorization

Child's Name: _____ Birthdate: _____

Medication: _____ Dosage: _____ Route _____

To be given at the following time(s): _____ Special Instructions: _____

Purpose of medication: _____ Side effects to be reported: _____

Starting Date: _____ Ending Date: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority Date

_____ _____/_____
Print Name of Health Care Provider Phone Fax Number

_____
Date

_____
Designated Camp Staff Signature