

REQUIRED FOR SOUND TO SEA PARTICIPATION

Name _____
School _____

Student Medical Form

Name _____ Age _____
Address _____ City _____ State _____ Zip _____
Date of Birth ____ - ____ - ____ Sex ____ Weight _____ Height ____ ft ____ in

Parents or Guardians _____	
Home Phone (____) _____ - _____	Work Phone (____) _____ - _____
Home Phone (____) _____ - _____	Work Phone (____) _____ - _____
Cell Phone (____) _____ - _____	Cell Phone (____) _____ - _____
Family Physician/Doctor _____	Phone (____) _____ - _____
In case of emergency, notify the following if a parent cannot be reached:	
Name _____	Relationship _____ Phone (____) _____ - _____
Name _____	Relationship _____ Phone (____) _____ - _____

**These must
be filled in.**

Home and Health Questionnaire

1. Please give the date of the student's last diphtheria-tetanus or tetanus booster _____.
2. Please list any current activity restrictions or special health concerns such as recent sprains, fractured bones, recent hospitalizations, learning disabilities, physical disabilities, special diet (vegetarian/religious restrictions) _____

3. Does the student have a history of: (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional/psychological condition | <input type="checkbox"/> Musculoskeletal disorder |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart defect/disease | <input type="checkbox"/> Homesickness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Other health conditions: |
| <input type="checkbox"/> Ear/Throat infections | | |

Explain the health conditions checked above: _____

4. Please tell us if your student has any allergies: (Food, Medication, Insect Bite/Sting, Seasonal, Other)

My child is allergic to _____
It is an allergy of (circle all that apply) **ingestion, contact, inhalation, other** _____
The **severity of the reaction is** (hives, stomach ache, anaphylactic reaction, etc) _____

Recommended **treatment** for reaction _____

My child is **ALSO** allergic to _____
It is an allergy of (circle all that apply) **ingestion, contact, inhalation, other** _____
The **severity of the reaction is** (hives, stomach ache, anaphylactic reaction, etc) _____

Recommended **treatment** for reaction _____

Please list any additional allergies on the back of this form.

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Student Covid-19 Pre Screening Form

Sound to Sea Environmental Education Program is committed to creating a safe and healthy environment for all participants and staff. In an effort to minimize the risk of illness on property we ask you first start at home. Please bring this completed form to Sound to Sea on arrival.

COVID-19 SYMPTOM LIST

- Cough
- Shortness of breath or difficulty breathing
- Fever/ Chills
- Muscle Pain
- Sore Throat
- New loss of taste or smell
- Nausea/ Vomiting/ Diarrhea

PLEASE INITIAL If TRUE

1. My child has not had contact with anyone with Covid-19 symptoms or has been diagnosed with Covid-19 in the 14 days before the start of the program. _____
2. No one in our household has been sick in the 14 days prior to the program. _____
3. My child has not traveled by air or traveled out of state in the 14 days before the program. _____
4. My child has adhered to NC State's guidelines regarding Covid-19 (including social distancing and mask wearing in public) for the 14 days prior to the program. _____
5. My child understands that mask wearing will be mandatory to attend this program. _____

14 DAY TEMPERATURE CHECK:

Please fill this form out beginning 14 days prior to you start date of the program.

Program Start Date: _____ Covid-19 Screening Start Date: _____

DAY	14	13	12	11	10	9	8
Temp/ Symptom							
DAY	7	6	5	4	3	2	1
Temp/ Symptom							

Our signature below indicates we completed this health screening daily for 14 days prior to the program and to the best of our ability. We understand that arriving at Sound to Sea healthy protects ourselves, students and staff.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____