



## 2015-2016 -- 6<sup>th</sup> Grade

### Expedition:

#### **Wondersruck:**

How Innovation, Invention and Creativity have shaped our world

Products may include:

Personal Museum Exhibit

Rube Goldberg Machines

Student-designed and built Musical Instruments

Minnesota Children's Museum Exhibit Design

### Core Classes (year long)

- **English: Reader's and Writer's Workshop -- double period**
- **Social Studies: Minnesota Studies**
- **Physical Science**
- **Math\*:** Math 6 (double period)  
Pre-Algebra – grade 7 (double period)  
Algebra I – grade 8 (single period)

\*We will use Elementary teacher recommendations as well as OLPA and MCA data to identify students that need to be accelerated in math.

### Support Classes:

- **Journalism (semester or full year)**
- **Creative Writing (semester)**
- **Art (semester)**
- **Physical Education (semester)**
- **Theater Arts (semester)**
- **Music Exploration (semester)**
- **Spanish for Spanish Speakers: Fluent, Literate Spanish only (full year).**
- **Spanish I (full year)**



## Baker Park Reserve Trip Schedule and Information October 1-2, 2015

All 6<sup>th</sup> graders are invited to our fall overnight. Please try to make sure your student is available for this fun and important trip.

The objective of our trip is to begin the school year with an experience that will build lasting friendships and provide the foundation for future collaborative fieldwork. Baker Park is a beautiful location that provides the perfect backdrop for our activities.

This will be an action-packed 2 days of canoeing, archery, cooperative games, rock climbing and more! Whether your student has participated in these activities in the past or not, there will be training and support for every activity we do and we'll all learn together.

**COST:** The total cost of the trip will be: **\$60**. This will include transportation, meals, lodging and the classes offered by the Baker staff. Checks can be made out to: OWL. **Payment due by September 22 to the office.**

**LOCATION:** Baker Park Near-Wilderness Settlement in Maple Plain, MN, approximately 45 minutes west of St. Paul. The students and staff will stay in simple cabins with bunk beds. The cabins do not have electricity. There is a central lodge/program building where OWL students and staff will eat their meals. Bathrooms are located in the lodge.

For more information about this beautiful facility:

<http://www.threeriversparks.org/parks/baker-park/baker-near-wilderness.aspx>

**Emergency Numbers:**

Baker Near Wilderness Settlement: 763-694-7856

OWL Staff Dave Gundale: 651-262-8935

**Buses will depart for the trip** at 8:30 a.m. from Open World Learning Community on Thursday, October 1. Students are expected to be at school at the normal start time, 7:30 a.m. Students should bring their gear for the trip on the school bus with them. We will return by the end of the day October 2 and students will take the school bus home.

**Questions before the trip:** contact Tim Leone-Getten @ 651-293-8670

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**Baker Near-Wilderness Settlement---- October 1-2, 2015**

Student name: \_\_\_\_\_ Crew Leader: \_\_\_\_\_

Amount enclosed: \$ \_\_\_\_\_

Please detach the bottom of this sheet and return in the enclosed envelope

## **Baker Park Packing List:**

**All items should be marked with the student's name.** Masking tape works well for this—even on the inside of clothes.

Please have your child pack into a small bag -- preferably their backpack -- as this is a short trip and only a small amount of clothing is needed. Their sleeping bag can be carried separately.

### **Personal Gear:**

- Sleeping bag
- Washcloth & soap
- Toothbrush and toothpaste
- Medications
- Water bottle
- Pillow

### **Clothing:**

- Tennis shoes
- 1 long sleeve shirt/light jacket
- 1 short sleeve shirt
- Long pants
- Shorts
- Underwear
- 2 pairs of socks

### **Optional Gear**

- Camera
- Sunglasses
- Hat
- Book
- Flashlight

### **Please DO NOT bring the following items:**

- Cell Phone (if student needs phone, we can collect them and keep them safe during trip)
- Ipod or MP3 player
- Electronic games
- Any other electronics not listed here
- Electrical appliance (such as blow-dryers)
- Make up
- Candy/food-- **ALL FOOD IS PROVIDED AT THE SITE.**



## 2015-16 Conferences

At Open World Learning Community, we believe that students do best when their families are informed and involved in their education. **For this reason, our crew leaders hold three required conferences with students and families each year.** We also have two other conference days in November and April by request of teachers or families.

### Goal-Setting Conferences

One unique aspect of conferences at OWL-- which we feel it is vitally important -- is that crew leaders hold planning conferences the week before school starts with each student and family. We feel that planning for a year of challenge and success needs to take place at the beginning of the year. This conference will be a chance to set academic and social goals, review class schedules and get to know each other.

### Student-Led Conferences

End-of-semester conferences in January and May are led by students, who exhibit their portfolio of work to their parents and Crew leader. In all conferences, students take a leading role, showing ownership of their accomplishments and challenges. Students work in their crews to prepare for each conference session, gathering samples of high quality work from each course and rehearsing the presentation of their work.

**Note: Your crew leader will contact you during the weeks of August 10 and August 17 to set up your goal-setting conference. Conferences will be held:**

- **Wednesday, September 2 from 4-8 PM**
- **Thursday, September 3 from 2-6 PM**

**If you have not received a call from your crew leader by August 22, please contact Principal Dave Gundale at: 651-293-8670/dave.gundale@spps.org**

\*Your conference will last 25 minutes, but we ask you to come 20 minutes early to fill out important forms if you did not do so in the spring.

### What to bring with you to goal-setting conferences September 2-3:

- **Your child**
- **Any contact info you need for emergency and health forms (health insurance, doctor, dentist, emergency contact, etc.).**
- **Your checkbook or cash to pay for expedition fieldwork and fall orientation trips.**
- **Look at your calendar for February 3-4, 2016 to sign up for a student-led conference.**

# Open World Learning Community School Supplies List

You can bring your school supplies to your goal-setting conference on September 2 or 3 or to the first day of school.

Community Items (to be given to your crew leader at your conference or on the first day): Teachers can use all of these items. Please bring as many as you are able.

- 3-5 Boxes of Kleenex
- Pack of Glue Sticks/Hot glue gun sticks
- Scotch tape/Masking Tape
- Box(es) of pencils to share (Ticonderoga brand preferred)
- Pack of Markers or Colored Pencils
- Dry Erase Markers/Sharpies
- Post-It Notes/Index Cards
- Target/Office Max gift card for miscellaneous supplies

Personal Items for all students (needed the first day):

- Backpack
- Jump drive/memory stick (optional)
- iPad Stylus (optional)
- Pens and pencils (get enough for the entire year)
- Highlighter pens
- 8 Pocket Folders
- 8 College-ruled notebooks
- 1 Sewn-bound quad (grid) composition-size notebook OR \$3.00 to buy them from your teacher
- Calculator: TI30XIIS (or you can get the more luxurious TI83 or 84)
- Physical Education: Tennis shoes
- AP Biology: 3 ring binder (2-3 inch)

**\*\*Consider buying more for those who can't afford as much. You can give any donations to your crew leader.**



## Middle School Athletics 2015-16

At OWL, we offer the following sports for grades 6-12:

**Archery** (November- March main season, weekly rest of the year)

**Ultimate Frisbee** (March-June, weekly in the fall)

In grades 6-8, if you wish to participate in another sport, Open World Learning Community has a cooperative relationship with the athletic program at **Humboldt Middle School**. Students must **get themselves home** after practices or games.

If you are interested in participating in athletics (beyond those listed above), please refer to the St. Paul Public Schools website [sports.spps.org](http://sports.spps.org) for forms and instructions.

Any questions regarding athletics can be directed to:

Dave Mergens, Humboldt/OWL Athletic Director 651-744-5640/[david.mergens@spps.org](mailto:david.mergens@spps.org).

### 6<sup>th</sup> – 8<sup>th</sup> Grade at Humboldt Junior High School

Middle school sports start the second week of school.

You can sign up at goal-setting conferences or the first week of school.

#### Fall Athletics

Volleyball (girls)

Boys Soccer

Girls Soccer

Flag Football (Boys and Girls)

#### Winter Athletics

Wrestling (Boys and Girls)

Girls Basketball

Boys Basketball

Alpine Skiing (CO-ED) Grades 7-12 (at Central)

Nordic Skiing (CO-ED) Grades 7-12 (at Central)

Girls Gymnastics (not at Humboldt/Possible at Central)

#### Spring Athletics

Baseball (boys)

Softball (girls)

Golf (boys and girls)

Badminton (girls)

Track & Field (boys and girls)

Child's Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Child's Legal Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

**Open World Learning Community**  
**2015-2016**

Male  Female Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_

Address \_\_\_\_\_ House No. \_\_\_\_\_ Street \_\_\_\_\_ Apt. # \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_  
 Last School Attended \_\_\_\_\_

List all St. Paul Schools your child has attended \_\_\_\_\_

Has your child ever received Special Education services?  No  Yes If yes, please describe services \_\_\_\_\_

Child lives with:  Both Parents  Mother  Father  Guardian

Circle One: Mother Father Stepmother Stepfather Guardian NAME \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_ Email \_\_\_\_\_

Circle One: Mother Father Stepmother Stepfather Guardian NAME \_\_\_\_\_ Work Telephone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_ Email \_\_\_\_\_

DAY CARE ONLY (Name, Address & Phone) \_\_\_\_\_

**EMERGENCY CONTACTS (other than parents listed above):** This is VERY important! If your child becomes ill, or if school closes for the day for an emergency, we must be able to contact someone who can care for and pick up your child. **PHONE NUMBERS MUST BE KEPT CURRENT!**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

\*Other adults who may pick my child up from school: \_\_\_\_\_

List Brothers or Sisters at O.W.L. Community:  
 \_\_\_\_\_ Grade \_\_\_\_\_  
 \_\_\_\_\_ Grade \_\_\_\_\_  
 \_\_\_\_\_ Grade \_\_\_\_\_

**OFFICE USE**

Year \_\_\_\_\_ CIF \_\_\_\_\_ EC \_\_\_\_\_ Records Requested \_\_\_\_\_  
 Grade \_\_\_\_\_ Teacher \_\_\_\_\_ Records Received \_\_\_\_\_  
 Admit Date \_\_\_\_\_ Withdrawal date \_\_\_\_\_ To \_\_\_\_\_

Transportation: **OFFICE USE**

Bus \_\_\_\_\_ Bus Stop \_\_\_\_\_  
 Parent Pick Up \_\_\_\_\_  
 Patrol Line (Color) \_\_\_\_\_



O

W

L

GRADES 6-12

## Family Communication Information Form

Building a strong community around our students is our main goal, and keeping parents and families informed is key to that goal. E-mail is the most efficient way for us to communicate with you about conferences, your student's class work and field trips, important forms, announcements, school and family events, volunteer opportunities (in the school, through site council and PTO) and more.

By providing us with the following information, you authorize the school to contact you with important information that will help you stay informed.

Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Crew Leader: \_\_\_\_\_

Parent 1 Name: \_\_\_\_\_

Parent 2 Name: \_\_\_\_\_

Primary Address: \_\_\_\_\_  
\_\_\_\_\_

Home/Main family phone: \_\_\_\_\_

Parent 1 cell phone: \_\_\_\_\_ Text ok? Yes  No

Parent 2 cell phone: \_\_\_\_\_ Text ok? Yes  No

Student cell phone: \_\_\_\_\_ Text ok? Yes  No

Parent 1 email: \_\_\_\_\_

Parent 2 email: \_\_\_\_\_

Student email: \_\_\_\_\_





SAINT PAUL PUBLIC SCHOOLS  
FIELD TRIP PARENTAL/GUARDIAN AUTHORIZATION FORM  
TYPE II FIELD TRIPS

A field trip to:  
End of Quarter Incentive Trips and End of Year Celebration  
Nov 13 Corn Maze at Waldoch Farms, Lino Lakes  
Jan 28 Riverview Theater, Minneapolis  
April 1 Wooddale Funzone Rollerskating, Woodbury  
June 9 Valleyfair or Como Park  
June 10 Lake Elmo Park Reserve

is planned by: Open World Learning Community  
for the purpose of:  
End of Quarter incentive for students and end of year celebration (Lake Elmo)

The attached form must be completed and returned before the student will be permitted to participate in the above field trip.

VERBAL APPROVAL WILL NOT BE ACCEPTED  
\*\*\*\*\*

Detach and Return

Field Trip Parental Authorization

I/We authorize \_\_\_\_\_ to participate in the field trip.  
Student's Full Name

to Nov 13 Corn Maze at Waldoch Farms, Lino Lakes  
Jan 28 Riverview Theater, Minneapolis  
April 1 Wooddale Funzone Rollerskating, Woodbury  
June 9 Valleyfair or Como Park  
June 10 Lake Elmo Park Reserve

Does the student have any special health problems or handicapping conditions which will require special attention or supervision on this field trip? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is this problem and what special considerations should be made?  
\_\_\_\_\_  
\_\_\_\_\_

We understand that the necessary arrangements, plans, and precautions will be taken for the care and supervision of the student during the trip.

Date \_\_\_\_\_ Signature of Parent(s) or Guardian(s) \_\_\_\_\_

Telephone: Address:  
Day Time \_\_\_\_\_  
Emergency \_\_\_\_\_



Form Due: \_\_\_\_\_

Medications Due to the Health Office: \_\_\_\_\_

Type of field trip and destination: \_\_\_\_\_

Teacher in Charge: \_\_\_\_\_ Date(s) of trip: \_\_\_\_\_

### Overnight Field Trip Health Form

Student's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone (Home/Cell): ( \_\_\_\_\_ )

Parent/Guardian: \_\_\_\_\_ Phone (Home/Cell/Work): ( \_\_\_\_\_ )

Parent/Guardian: \_\_\_\_\_ Phone (Home/Cell/Work): ( \_\_\_\_\_ )

Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

#### Health Information:

Severe allergies/anaphylaxis (please specify):

Food: \_\_\_\_\_ Drug: \_\_\_\_\_ Bee Sting: \_\_\_\_\_ Other: \_\_\_\_\_

Please ✓ all that apply:

Asthma	_____	Seizures	_____	Other	_____
Diabetes	_____	Sickle Cell	_____		_____
Heart Condition	_____	Bed Wetting	_____		_____

911 or Emergency Medical Services will be called in the event of a medical emergency and the student will be transferred to the nearest medical facility.

I hereby give permission for emergency care to be secured by the school staff and understand that, should a medical emergency arise, every effort will be made to contact me before such care is given. We understand the arrangements described for this and believe that the necessary precautions/plans for the care and supervision of the students will be taken during this trip. Beyond this, we will not hold the school or those supervising the trip responsible. I do give consent for my child to go on this trip.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Complete reverse side.*

### Medication:

The administration of any medication to students on any field trips shall be done only when the student has a medical condition that may be adversely affected without medication. This applies to both prescription and non-prescription medication.

Prescription medication **MUST** come in the pharmacy labeled container with the student's name, pharmacy and telephone number, name of physician, drug name, dosage and time to be given. Non-prescription medication **MUST** come in its original container and be labeled/marked with the student's name.

**\*\*All medication requires Licensed Provider order and signature\*\***

### Parent/Guardian Request:

I request that the following medications be given to my child:

Student's name: \_\_\_\_\_ DOB: \_\_\_\_\_

while participating in the field trip. I release school personnel from any liability in relation to the administration of these medications. I authorize the reciprocal release of information related to medication between the nurse and the prescribing health professional.

#### Middle School and Secondary Students Only:

\_\_\_\_\_ I have signed a Secondary (6<sup>th</sup> - 12<sup>th</sup> Grade Students) Authorization to Self-Carry/Self-Administer Over-the-Counter (OTC) Pain Relief Medications (H-76OTC)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Side effects to watch for: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Side effects to watch for: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Side effects to watch for: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Side effects to watch for: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Side effects to watch for: \_\_\_\_\_

### Licensed Prescriber Order:

I have prescribed the above medication(s) for this child and request the dosages be given at the indicated times.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone of prescriber: ( \_\_\_\_\_ ) \_\_\_\_\_



**OUTWARD BOUND  
ACKNOWLEDGEMENT AND ASSUMPTION OF RISKS and  
LIABILITY RELEASE AND INDEMNITY AGREEMENT**

In consideration of the services of Voyageur Outward Bound School, and its chartering organization, Outward Bound, Inc., and its affiliated Outward Bound Services Group, (collectively referred to as "OB"), participant (and parent or legal guardian of a minor participant) acknowledge(s) and agree(s) as follows:

I understand that participant (and parent) share(s) the responsibility for participant's safety. I have (or my child has) no mental or physical problems or limitations that might affect my (or my child's) ability to participate that have not been disclosed to OB in writing. I have had the opportunity to ask questions about the activities and the risks of the program in which I (or my child) will participate. I agree to obey all OB rules, regulations, and policies (and have my child obey them).

The activities in which I (or my child) may participate will depend on the program in which I am (or my child is) enrolled and may be physically strenuous. These activities may include but are not limited to: hiking; camping; rock, wall or tower climbing; ropes and/or challenge courses (traversing ropes suspended off the ground, potentially at great heights, swinging or traveling by a cable and pulleys and other such activities); physical problem-solving activities; water activities including swimming; vehicle travel; and community and other service projects that may involve using power tools. I understand that I (or my child) may engage in other activities not described above. It is impossible to know or list every risk associated with every activity; however, I understand the risks I (or my child) may encounter include but are not limited to: slipping, falling, being struck by or striking objects, persons or the ground; improper or malfunctioning equipment or structures; disease carrying or poisonous plants, insects, or animals; and physical contact with other participants. These and other risks are inherent to the activities, which means that they cannot be changed or eliminated without altering the essential elements of the activity.

I acknowledge that participating in an OB program involves inherent risks and other risks, including some not described above, that can cause or lead to death, injury, illness, or property damage. I understand that OB cannot assure my (or my child's) safety and does not seek to eliminate all of these risks, in part, because they facilitate educational and other objectives. I agree to assume all of the risks of the activities in the program, whether inherent or not, and even if not described above.

I hereby forever release, waive and discharge OB and each of OB's respective agents, affiliates, employees, officers, directors, trustees, independent contractors, volunteers, and all other persons or entities acting under their direction and control (collectively "the Released Parties") from, and agree not to pursue a claim or sue the Released Parties or any of them, for any liability, claim, or expense in any way associated with my (or my child's) enrollment or participation in the OB program or the use of any equipment or facilities. Neither I nor anyone acting on my (or my child's) behalf will make a claim against the Released Parties as a result of any injury, illness, damage, death, or loss. This release includes any losses caused or alleged to be caused, in whole or in part, by the negligence, whether active or passive, of the Released Parties to the fullest extent allowed by law (but not for gross negligence) and includes claims for injury, property damage, wrongful death, breach of contract, or any other type of suit.

I further agree to defend and indemnify the Released Parties (to pay or reimburse them for money they are required to pay, including attorneys' fees and costs) with respect to any and all claims brought by or on behalf of me, my child, a family member, personal representative, estate, heir, next of kin, assigns, a co-participant, or any other person for any claims related to my (or my child's) enrollment or participation in the program or my (or my child's) use of equipment or facilities, including claims that the Released Parties were negligent.

I agree that the substantive law of Minnesota (but not any law that would apply the laws of another jurisdiction) governs this document and any dispute or suit I have (or my child has) with the Released Parties. Any mediation, suit, or other proceeding must be filed or entered into only in Minnesota. Any portion of this document deemed unlawful or unenforceable is severable and shall be stricken without any effect on the enforceability of the remaining provisions. OB has permission to use my photo or image for sale or reproduction in any manner it desires, including advertising or display.

**I HAVE CAREFULLY READ, UNDERSTAND, AND VOLUNTARILY SIGN THIS DOCUMENT. I UNDERSTAND THAT I AM SURRENDERING CERTAIN LEGAL RIGHTS. I HEREBY WARRANT THAT I HAVE LEGAL AUTHORITY TO ACT ON BEHALF OF MY CHILD. I AGREE, ON MY OWN AND ON MY CHILD'S BEHALF, TO THE TERMS AND CONDITIONS IN THIS DOCUMENT.**

*If participant is under the age of 18 (or if participant is a resident of Alabama and is under the age of 19) (or if participant is a resident of Mississippi and is under the age of 21) at the time this document is signed, at least one parent or legal guardian must sign the release in addition to the participant signing.*

_____	_____	_____	_____
Participant signature	Date	Print name here	Date of Birth and Age
_____	_____	_____	
Parent or Guardian signature	Date	Print name here	



OFFICE USE ONLY

FOLLOW-UP

APPROVAL

INSTRUCTIONS All the questions on this form are important. The answers are needed in order to assess your level of participation in the program. Please answer every question in every section and return the form as soon as possible, in order to allow time for any needed follow-up. Incomplete forms will slow down the screening process, and may cause you to miss out on your Outward Bound program. Please write legibly in blue or black ink.

PART I - GENERAL INFORMATION PROGRAM/COURSE NUMBER: START DATE:

Applicant

Name: Age at Program Start: DOB: Address: Height: inches City/State/Zip: Weight: lbs. Home Phone: BLOOD PRESSURE - Taken within 6 months of course start Cell Phone: Blood Pressure: E-mail: Date Taken: Gender: Male Female Blood pressure may be taken with apparatus at a local grocery or drug store.

Parent/Custodial Guardian (if applicant is under the age of 18)

Name: Relationship to Applicant: E-mail: Occupation: Address: City/State/Zip: Cell Phone: Home Phone: Work Phone:

Emergency Contact (not a parent or guardian)

Name: Relationship to Applicant: Home Phone: Cell or Work Phone:

Ethnic Background (optional)

- Asian, Multi-Ethnic, Hispanic or Latino, Caucasian (Non-Hispanic), Native Hawaiian or Pacific Islander, African American, American Indian/Alaskan Native, Do Not Know Ethnicity, Other:

Insurance Information

If you have insurance, please attach a photocopy of both the front and back of your insurance card. Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance.

PART II - MEDICAL INFORMATION

A. ALLERGIES Include allergies to medications, foods, insect bites/stings, environmental, etc.

NONE (OR LIST TO RIGHT)

Table with 3 columns: Allergy List Below, Reaction List Below, Medications Required (if any)

B. MEDICATIONS YOU ARE CURRENTLY TAKING If psychiatric medication, please list any medications taken or changed within the past 3 months. Also list any over-the-counter, inhalers, herbal supplements, etc.

NONE (OR LIST TO RIGHT)

Table with 5 columns: Medication List Below, Taken For Symptom/Condition, Dosage Size/Frequency, Date Started, Current Side Effects (if any)

NOTE: If you are taking prescription medications, you MUST bring them in ORIGINAL PRESCRIPTION BOTTLES with the physician's dosage directions. If possible, bring a double supply. If there are any changes please contact Outward Bound.

**CURRENT EXERCISE ACTIVITY** Please list the activities you engage in daily or weekly which indicate your current level of physical activity. You will be expected to participate in rigorous physical activity during your program. If you are currently experiencing a medical condition, you should consult your physician in preparation for your program.

NONE  
(OR LIST TO RIGHT)

Activity	Frequency	Time/Distance	Leisurely	Moderately	Intensely
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PART III - HEALTH PROFILE** Please check an answer for each question, if yes please describe below.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (If yes, please bring inhaler)	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization/Emergency Room/Urgent Care visit w/in past year
<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	Seizure within the past 6 months
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac conditions, e.g., heart murmur or other rhythm abnormality	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, dizziness or faint spells
<input type="checkbox"/>	<input type="checkbox"/>	Current orthopedic problems(neck/back/knee/shoulder)	<input type="checkbox"/>	<input type="checkbox"/>	Use of tobacco/smoker
<input type="checkbox"/>	<input type="checkbox"/>	Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Other medical issues/illnesses/symptoms/requirements/prosthetic device(s)

Describe: \_\_\_\_\_

**PART IV - PERSONAL HISTORY** Based on the past one year.

1. Have you been diagnosed or treated for any of the following disorders currently or within the past year?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Adjustment Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Disorder (ADD)
<input type="checkbox"/>	<input type="checkbox"/>	Developmentally Disabled	<input type="checkbox"/>	<input type="checkbox"/>	Disruptive Behavior Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Impulse Control Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pervasive Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>	Substance Related Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			

2. Have you received treatment or therapy for any of the following, either currently or in the past year?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Medication(s)	<input type="checkbox"/>	<input type="checkbox"/>	Out Patient Counseling
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	Residential Treatment			

3. Have you experienced any of the following significant events within the past year? If yes, please describe below.

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Death of Family/Friend	<input type="checkbox"/>	<input type="checkbox"/>	Expulsion	<input type="checkbox"/>	<input type="checkbox"/>	Incarceration
<input type="checkbox"/>	<input type="checkbox"/>	Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	Serious Accident/Injury	<input type="checkbox"/>	<input type="checkbox"/>	Serious Illness

Describe: \_\_\_\_\_

4. Please arrange for a release of information with your therapist and/or prescribing physician so we may contact them for further information as part of this screening process. Have you done so?  Yes  No

5. Please provide the name and telephone & fax #s of your therapist and/or prescribing physician:

Prescribing Physician Name: _____	Therapist Name: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____
Email: _____	Email: _____

**PART V - SIGNATURE REQUIRED**

All information will remain confidential except that information may be disclosed to a medical provider as needed for my (or my child's) care. Over the years, many participants with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Failure to disclose medical information could result in serious harm to you (or your child) and fellow participants. I understand that I may be in an area where communication, transportation, or evacuation is subject to delay. I (or my child) will be attending an Outward Bound program and I give permission for any emergency anesthesia, operation, hospitalization or other treatment that may become necessary. I agree to be responsible for any and all charges associated with such treatment.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required if applicant is under the age of 18 OR if applicant is a resident of Alabama and is under the age of 19 OR if applicant is a resident of Mississippi and is under the age of 21.)

SAINT PAUL PUBLIC SCHOOLS  
FIELD TRIP PARENTAL/GUARDIAN AUTHORIZATION FORM  
TYPE II FIELD TRIPS

A field trip to: Science Museum of Minnesota (Sept 29), the Bell Museum of Natural History and Weisman Museum of Art (Sept 30), Minnesota Children's Museum (various dates)

is planned by: Kevin Hansen, Rebecca Palmer, Dan Sullivan  
for the purpose of: Grade 6 Wonderstruck Fieldwork

Cost: \$20

The attached form must be completed and returned before the student will be permitted to participate in the above field trip.

VERBAL APPROVAL WILL NOT BE ACCEPTED

\*\*\*\*\*

Detach and Return

Field Trip Parental Authorization

I/We authorize \_\_\_\_\_ to participate in the field trip.  
Student's Full Name

to Science Museum of Minnesota (Sept 29), the Bell Museum of Natural History and Weisman Museum of Art (Sept 30), Minnesota Children's Museum (various dates)

Does the student have any special health problems or handicapping conditions which will require special attention or supervision on this field trip? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is this problem and what special considerations should be made?

\_\_\_\_\_

We understand that the necessary arrangements, plans, and precautions will be taken for the care and supervision of the student during the trip.

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent(s) or Guardian(s)

Telephone:  
Day Time \_\_\_\_\_  
Emergency \_\_\_\_\_

Address:  
\_\_\_\_\_  
\_\_\_\_\_



SAINT PAUL PUBLIC SCHOOLS  
FIELD TRIP PARENTAL/GUARDIAN AUTHORIZATION FORM  
TYPE III - NATIONAL/INTERNATIONAL TRAVEL

A field trip to: Baker Near-Wilderness Settlement  
Is planned by: Rebecca Palmer  
For the purpose of: OWL Fall Retreat: Grades 6-7 Middle School Orientation  
On (dates) Tuesday September 29, 2015 to Wednesday, September 30, 2015  
Or Thursday October 1, 2015 to Friday, October 2, 2015  
The attached form must be completed and returned before the student will be permitted to participate in the above field trip.

**VERBAL APPROVAL WILL NOT BE ACCEPTED**

Detach and Return

Field Trip Parental Authorization

Students Full Name

Open World Learning Community  
School

Family Name

Does this student have any special health problems or handicapping conditions which will require special attention or supervision on this field trip? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is this problem and what special considerations should be made? \_\_\_\_\_

We understand that arrangements, plans, and precautions will be taken for the care and supervision of the student during the trip.

I/we authorize \_\_\_\_\_ to participate in the field trip

Student's Full Name

To Baker Near-Wilderness Settlement on (date) September 29-30 or Oct 1-2, 2015  
The undersigned parent or guardian, on behalf of \_\_\_\_\_

In consideration of participation by the student in said field trip, herewith assumes all risks of said trip, and agrees to hold harmless Independent School District No. 625 for all damages for injury to a person or property arising out of any act not under control of said School District, including but not limited to the following: insurrection, revolution, air piracy, abduction, kidnapping, any act of aggression by a foreign government of its citizens, civil war or rebellion, and any act whether accidental or otherwise perpetrated by anyone not under the direct control of said School District.

Telephone #: Home: \_\_\_\_\_

Work: \_\_\_\_\_

Signature parent/guardian \_\_\_\_\_

Date: \_\_\_\_\_

Signature parent/guardian \_\_\_\_\_

Date: \_\_\_\_\_

(if more than one, both parents/guardians must sign)

# BAKER NEAR-WILDERNESS SETTLEMENT HEALTH FORM

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Parent #1 or \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_  
Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_ Phone \_\_\_\_\_  
Parent #2 or \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_  
Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_ Phone \_\_\_\_\_

If unable to contact parent in an emergency, call: \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to child \_\_\_\_\_

Name of child's Health Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Physician \_\_\_\_\_ Clinic Phone \_\_\_\_\_

**Current Health Information** – please indicate where applicable, and complete the information that applies to the above child. Information will be kept confidential. Use additional sheet if necessary.

\_\_\_\_\_ Asthma: List triggers \_\_\_\_\_ Treatment currently used? \_\_\_\_\_

\_\_\_\_\_ Special dietary regimen or food allergies: please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Other allergies, list \_\_\_\_\_  
Does child carry epinephrine? \_\_\_\_\_

\_\_\_\_\_ Seizures: list all related medications below under "Current Medications"

\_\_\_\_\_ Activity restrictions: describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Heart condition: describe \_\_\_\_\_ What is the treatment? \_\_\_\_\_

\_\_\_\_\_ Sleep problems: please circle: bedwetting sleepwalking other \_\_\_\_\_

\_\_\_\_\_ Other important medical information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current medications:**  
Please list all prescription medication your child will be taking at the Baker Near-Wilderness Settlement. (include inhalers, nebulizer, ritalin, etc.) Use additional forms if needed.

**All prescription medication must be in a current pharmacy labeled bottle.**

Name of 1<sup>st</sup> medication \_\_\_\_\_ Reason given \_\_\_\_\_

Amount given \_\_\_\_\_ Days and time needed \_\_\_\_\_

Name of 2<sup>nd</sup> medication \_\_\_\_\_ Reason given \_\_\_\_\_

Amount given \_\_\_\_\_ Days and time needed \_\_\_\_\_

Name of 3<sup>rd</sup> medication \_\_\_\_\_ Reason given \_\_\_\_\_

Amount given \_\_\_\_\_ Days and time needed \_\_\_\_\_

List any over-the counter medications your child can have while at the Baker Near-Wilderness Settlement. (include Tylenol, Ibuprofen, Sudafed) Indicate medication and administration instructions, (time, amounts, and circumstances). No aspirin will be given. Child will receive only the recommended doses of medication listed below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

All medication must be sent from home in **original over-the-counter container**.

**IMMUNIZATIONS**

Please note month/year administered.

- \_\_\_\_\_ MMR
- \_\_\_\_\_ DPT
- \_\_\_\_\_ Tetanus Booster
- \_\_\_\_\_ Polio

**Permissions and Emergency Authorization for above named child:**

1. This child has my permission to participate in a field trip to and all activities at the Three Rivers Park District Baker Near-Wilderness Settlement except as noted by me. This health history is correct so far as I know. This child has no known communicable disease(s) at this time.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

2. Staff have my permission to give this child the listed medications at the times and the amounts indicated.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

3. Three Rivers Park District staff have permission to transport the child for educational and/or emergency reasons. I hereby give permission in a medical emergency to the physician selected by the child's group leader or Three Rivers Park District staff to hospitalize and secure treatment for the child. I understand every effort will be made to reach me at the phone numbers listed above.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

## THREE RIVERS PARK DISTRICT CLIMBING TOWER Waiver Of Liability

Warning: This agreement is legally binding. By signing it, you give up your right to recover compensation, through the courts or otherwise, for any personal injuries, damage to your property or from your death, arising out of your use of the Three Rivers Park District Climbing Tower or your participation in classes, clinics or activities sponsored by the Three Rivers Park District. You will be releasing from Liability the owners, operators, staff, employees and any volunteers of the Park District Climbing Tower. You will also be releasing any persons who have designed, engineered, manufactured or installed the Park District Climbing Tower. This release is binding even if the released persons have contributed to your injuries or death through their individual or collective negligence. This agreement also requires you to indemnify and hold harmless the persons released from any losses, liabilities, damages and costs.

### Assumption and Acknowledgment of Risk

I, the undersigned, acknowledge and agree that the use of the facilities, climbing tower or equipment of the Three Rivers Park District Climbing Tower and the taking of classes, clinics or participating in the activities sponsored by the Three Rivers Park District has inherent risks. Those risks include but are not limited to:

1. Injuries resulting from the NEGLIGENCE of the owners, operators, staff, employees and any volunteers who may be present at the Park District Climbing Tower, or the NEGLIGENCE of the designers, engineers, manufacturers or installers of the facilities, climbing tower, or equipment of the Park District Climbing Tower, or the NEGLIGENCE of the Park District.
2. Injuries or death resulting from the failure or negligent misuse of the facilities, climbing tower or equipment of the Park District Climbing Tower facility.
3. Injuries resulting from slips, trips or falls while using the facilities, climbing tower or equipment of the Park District Climbing Tower facility, including but not limited to injuries incurred while using the climbing tower
4. Injuries resulting from the fall of other persons who may come into contact with me or from any falls in which I come into contact with other persons.
5. Injuries that occur from the NEGLIGENCE or lack of adequate training of those persons at the Park District Climbing Tower facility who seek to assist with medical or other help either before or after injuries have occurred.

Should I use my own equipment, I agree to indemnify and hold harmless the Park District for any injury caused to others as well as myself.

I am aware of these and numerous other inherent risks in using the Park District Climbing Tower facility. I assume complete responsibility for those risks and for the injuries that may occur as a result of those risks even if injuries occur in a manner that is not foreseeable at the time I sign this agreement. I realize that by voluntarily assuming the risks involved, I will be solely responsible for any loss or damage that I sustain, including personal injuries to me, damage to my property or damages arising out of my death.

In consideration of my observing or using the Park District Climbing Tower and/or in consideration of my participation in the classes, clinics, competitions or activities sponsored by the Park District, I

hereby agree to release from all liability, discharge and promise not to sue the Park District \_ or any member, owner, employee, staff or volunteer or any other climber, visitor or person present in or using the climbing tower or equipment of the Park District\_ or the designers, engineers, manufacturers or installers of the Park District Climbing Tower facilities or equipment.

This agreement releases the aforementioned persons from any liability to me, my heirs or next of kin, assigns or personal representatives, from any losses or damage or claims or demands arising out of my personal injuries, damage to my property or from my death.

I understand that I am releasing the aforementioned persons from all liability even if their individual or collective negligence contributes to or causes my personal injuries, damage to my property or my death.

If any provision of this agreement is held invalid, said invalidity shall not affect other provisions of this agreement which can be given effect without the invalid provisions, and to this end the provisions of this agreement are severable.

### INDEMNIFICATION AGREEMENT

In consideration of my observing or using the facilities, climbing tower or equipment of the Park District Climbing Tower facility and/or in consideration of my participating in the classes and activities sponsored by the Park District Climbing Tower, I agree to indemnify and hold harmless the persons released and discharged by me from any loss, liability, damages or cost that they may incur due to the presence of any claims or actions against or by me, my heirs, next of kin, assigns or personal representatives, arising out of my observing or using the facilities, climbing tower and/or equipment of the Park District Climbing Tower facility or arising out of my participating in the classes, clinics or activities of the Park District Climbing Tower facility, or in the case of a minor child for whom I am responsible, any claim or action arising out of the minor child's use of the facility and/or participation in the referred to above classes, clinics or activities.

I HAVE READ THIS AGREEMENT, INCLUDING BUT NOT LIMITED TO THE WAIVER OF LIABILITY AND ASSUMPTION AND ACKNOWLEDGMENT OF RISK SET FORTH ABOVE, THOROUGHLY AND UNDERSTAND THE TERMS. NO ORAL REPRESENTATIONS OR STATEMENTS OR INDUCEMENTS HAVE BEEN MADE TO ME THAT CHANGE, ALTER OR MODIFY ANYTHING WITHIN THIS WRITTEN AGREEMENT. I AGREE TO SAID TERMS. THIS DOCUMENT IS A LEGALLY BINDING CONTRACT WHICH SUPERSEDES ANY OTHER AGREEMENTS OR REPRESENTATIONS BY OR BETWEEN THE PARTIES AND WHICH IS INTENDED TO PROVIDE A COMPREHENSIVE RELEASE OF LIABILITY, BUT IT IS NOT INTENDED TO ASSERT ANY CLAIMS OR DEFENSES WHICH ARE PROHIBITED BY LAW. THIS AGREEMENT IS GOVERNED BY THE APPROPRIATE LAWS OF THE STATE OF MINNESOTA.

IF ANY OR PART OF THIS IS DETERMINED TO BE UNENFORCEABLE, ALL OTHER PARTS SHALL BE GIVEN FULL FORCE AND EFFECT.

\_\_\_\_\_  
Dates

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
I AM THE PARENT OR GUARDIAN OF THE MINOR  
AND I AM SIGNING THE RELEASE ON BEHALF OF THE MINOR.

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Parent/Guardian Signature