



2026

Health Advisory and Accommodation Form

that may require reasonable accommodations so that we understand what must be done to assure the best experience for them. While submission of this form may be required for participation in certain programs, the information you choose to disclose here is fully at your discretion. A new form may be required annually, or at another interval, but you may update it more frequently.

*Participant's Name: _____

*DOB: _____

*Parent/Guardian Name: _____

*Phone: _____

ALLERGIES: Be advised that facilities are not allergen-free zones. Peanuts/tree nuts, seeds, soy, latex items, and other allergens may be present. Some programs may include a snack item and/or communal meals. We cannot guarantee non-exposure.

PARTICIPANT IS ALLERGIC TO:	REACTION TRIGGERED BY:	HOW SEVERE IS THIS ALLERGY?	SYMPTOMS OF REACTION TO LOOK FOR:	BRINGING EPI-PEN?
	<input type="checkbox"/> Ingestion <input type="checkbox"/> Physical contact <input type="checkbox"/> Environmental	<input type="checkbox"/> Mild <input type="checkbox"/> Severe <input type="checkbox"/> LIFE-THREATENING		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Ingestion <input type="checkbox"/> Physical contact <input type="checkbox"/> Environmental	<input type="checkbox"/> Mild <input type="checkbox"/> Severe <input type="checkbox"/> LIFE-THREATENING		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please do not serve my child any food items. I will provide all snack and meal items.

Other comments regarding allergies: _____

MEDICAL CONDITIONS: Please list any medical conditions of which we should be aware. This may include short-term or chronic disease, mobility challenges, as well as physical, mental health, or learning disabilities. _____

MEDICATION ADMINISTRATION AUTHORIZATION: I authorize the Zoo to administer the following prescription medication(s) during program hours. Review our full Medication Policy in the Education Program Participation Agreement before completing.

MEDICATION NAME:	DOSAGE:	TIME TO ADMINISTER:	SPECIAL INSTRUCTIONS

Please allow my child to carry and self-administer their prescribed rescue inhaler. If not checked, staff will carry.

Other comments regarding medical conditions or medications: _____

ACCESS AND FUNCTIONAL NEEDS: Describe any access or functional needs and any accommodations requests:

Accommodation requests are evaluated on a case-by-case basis. A member of our staff will reach out to the parent/guardian for additional discussion, as needed. It is always our goal to be as inclusive as possible! To reach this goal we will make reasonable accommodations wherever we can to afford participation and services to individuals with disabilities and support needs, and in compliance with the Americans with Disabilities Act and all other applicable state and federal laws.

*Parent/Guardian Signature

*Date