MESD 4th Grade Overnight Health History Form (Please Print)

Confidential, for MESD Outdoor School Nurse and Site Supervisor use only. To be archived and destroyed by MESD.

MESD: 11611 NE Ainsworth Circle, Portland OR 97220 • 503-257-1600 • fax: 503-257-1592 • outdoorschool@mesd.k12.or.us

Teacher:

School:

**\*\*\*Return Form to your child’s teacher two weeks prior to attending Oregon Trail Program\*\*\***

**In order for your child to attend the 4th Grade Overnight, *all information* on this form must be completed and signed by a parent / legal guardian. If your child’s condition changes after you submit this form, please send a note to the Outdoor School nurse**.

# CONTACT INFO

Student’s Full Name:

Birth Date:

Age:

Sex:

Parent’s Name:

Home Phone:

Cell Phone:

Parent’s Work Phone

Parent’s Name:

Home Phone:

Cell Phone:

Parent’s Work Phone:

Student’s Address:

City:

Zip Code:

Family Doctor :

Phone:

Emergency Contact #1:

Relationship:

Phone:

Emergency Contact #2:

Relationship:

Phone:

# HEALTH INFO

Check all that apply:

□ ALLERGIES (\*please list below)

□ Asthma or other breathing problems

□ Bowel / Bladder Problems

□ Bedwetting

□ Diabetes

□ Emotional / behavioral or learning concerns

□ Hay Fever

□ Hearing Problem

□ Heart Problem

□ Mobility Issues

□ Physical Injuries (recent)

□ Seizure Disorder

□ Skin Problems

□ Sleep Walking

□ Vision Problems

□ Other chronic or recent illness or surgical procedure (specify):

\*Please provide more specific information about identified health concern including treatment needed while at the 4th Grade Overnight:

Are there any activity restrictions i.e. strenuous hiking, tug-of-war, etc?

Special dietary needs (vegetarian option could include eggs and dairy):

FOOD ALLERGIES: We do not knowingly serve food items with peanuts or tree nuts. However, some of the ingredients we use may be processed in facilities that also process nuts. Please list food allergies here, and contact our office if you have specific questions:

Other pertinent health information or safety concerns:

Other needs we should know about (privacy needs, anxiety/nervousness, etc.):

# MEDICATIONS

**If medication is needed during the Oregon Trail Program, the medication section of this form must be completed. Your child arrives at Oregon Trail at 10:15 a.m.**

□ **Please check here if your child needs to take medication between 10:00 and 12:00 noon.**

IF YOUR CHILD WILL NEED MEDICATION WHILE AT THE 4th GRADE OVERNIGHT, PLEASE READ AND COMPLETE THE INFORMATION BELOW AND ON THE NEXT PAGE.

**MEDICATION RULES**

1. All medication must be maintained and administered by the medication assistant. Medications include prescription, over-the- counter and vitamins/supplements. Children are not allowed to carry their own medication (except inhalers).
2. Any prescription, over-the-counter, or vitamins/supplements must have the following:
* Parent must sign the authorization below
* Parent must include the following:
	+ - **Name** of medication
		- **Dose** (strength and how much) of medication
		- **Times and Dates** medication should be given
		- **Purpose** or reason for medication
* All medication must be in original container (prescription, over the counter and vitamins/supplements). **No medications will be accepted or given if they are sent to Oregon Trail in unapproved containers (i.e., envelopes, baggies, etc.)**
* Prescription medication must have an accurate label. This includes samples given by the physicain. The direction on the prescription label must match exactly what you write on the parent/guardian authorization. **If the directions on the prescription label are different from what the physician is currently prescribing, written instruction is required from the physician.** See “physician Instructions” on page 3.
* Please send over the counter medications **only if absolutely necessary.** The medication assistant cannot administer any nonprescription medication containing alcohol, nor exceed doses in excess of label recommendations.
1. **All vitamins / supplements need a note from your health care provider in order to give, see OAR 581-021-0037.** The note needs to include name of student, name of vitamin/supplement, dose, time, purpose, signature from health care provider and date.

**(Examples are: melatonin, lactaid, daily vitamins, probiotics, herbs, homeopathic supplements, enzymes.)**

Over-the-counter medicine is not the same as vitamins / supplements. Over-the-counter medicine is approved by the FDA. Vitamins/supplements are not FDA approved and cannot be given without a note from the Health Care Provider.

**Sign here if you would like your child to carry and self-administer their emergency asthma inhaler and/or auto injector:.** (parent / guardian signature):

Name of inhaler and directions:

**\*this applies only to albuterol inhalers used on an as needed basis.**

Your child must be developmentally and behaviorally able to carry and self-administer his / her inhaler.

# PARENT / GUARDIAN AUTHORIZATION FOR 4th GRADE OVERNIGHT MEDICATION ASSISTANT TO ADMINISTER MEDICATIONS.

(Prescription, Over-the-Counter, Vitamins / Supplements)

I am requesting that my child:

be given or be assisted in taking the following medications:

**Name of medication:**

Dosage (amount):

Time:

Dates to be given:

Purpose of medication:

**Name of medication:**

Dosage (amount):

Time:

Dates to be given:

Purpose of medication:

**Name of medication:**

Dosage (amount):

Time:

Dates to be given:

Purpose of medication:

Parent / Guardian Signature:

Date:

# PHYSICIAN INSTRUCTIONS FOR ADMINISTRATION OF MEDICATION

(To be completed only by your child’s physician **if instructions are different from the label on the prescription bottle or if it is a vitamin / supplement.**)

I have prescribed the following medication(s):

**Name of medication:**

Dosage (amount):

Time:

Dates to be given:

Purpose of medication:

**Name of medication:**

Dosage (amount):

Time:

Dates to be given:

Purpose of medication:

**Name of medication:**

Dosage (amount):

Time:

Dates to be given:

Purpose of medication:

**Physician’s Name (print or stamp):**

**Physician’s Signature:**

**Date:**

**Address:**

**Zip Code:**

**Phone:**

# PERMISSIONS

**Legal parents / guardian contacted first whenever possible.**

In case of medical or surgical emergency, I hereby give permission to the Outdoor School / 4th Grade Overnight Coordinator to arrange transport for my child, as named above, to the hospital for evaluation by a physician.

Legal Parent’s or Guardian’s Signature:

Date:

Child’s Insurance Information:

**Medication Allergy:**