H-146
4/06

EDMONDS SCHOOL DISTRICT
HEALTH FORM FOR CAMP, OUTDOOR SCHOOL AND EXTENDED FIELD TRIP

Student's Name ___________________________________

Parent/Guardian ___________________________________

Address ____

____

Day Phone (______)________________________________ Evening Phone (______)____________________________

Pager/Cell (______)________________________________

Emergency Contact ________________________________ Relationship ______________________________________

Day Phone (______)________________________________ Evening (______)___________________________________

Check if you child has any of the following conditions:

- ❑ Asthma
- ❑ Bed Wetting
- ❑ Diabetes
- ❑ Food/Medicine Allergies
- ❑ Hay Fever
- ❑ Hearing Loss
- ❑ Heart Problems
- ❑ Insect Sting Allergy
- ❑ Menstrual Disorders
- ❑ Seizures
- ❑ Sleep Walking
- ❑ Vision Loss
- ❑ Other ________________________________

  ____

If checked above, please explain ____

____

____

____

Date of last tetanus shot ________________________________

If your child has any symptoms of illness or has been exposed to a communicable disease and may be in the infectious stage, <u>he/she needs to stay home.</u>

MEDICATIONS:
ALL medication (prescription and over-the-counter) kept by school staff must be in a pharmacy or manufacturer's container, which is clearly labeled. Please list all medication your child **must** take on the back. Contact your licensed health professional to complete his/her section of the medication form before returning it to school.

My child may self-administer ❑ Sunscreen ❑ Insect Repellent. To prevent eye injury please send non-aerosol forms of sunscreen and insect repellent.

LIFE THREATENING CONDITIONS:
If a student has a life threatening condition (for example: diabetes, seizure disorder, severe allergy, etc.), basic information about how to safely provide for the student will be shared with camp staff on a "need to know" basis.

MEDICAL RELEASE:
In the event of an accident or illness, I understand that reasonable effort will be made to contact the parent/guardian immediately. However, if I am not available, I authorize the school district to secure emergency medical care as needed.

Signature of Parent/Guardian ____ Date __________________________

(over)

EDMONDS SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTRATION
OF ORAL AND AUTO-INJECTABLE MEDICATION* AT SCHOOL

Student's Name: ____________________ Birthdate: ____________

School: ____________________ Grade: ____________

Medication is ordered to be given to a student at school only when absolutely necessary.

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP)
(e.g., MD, DO, ARNP, DDS, etc.)

NAME OF MEDICATION	DOSAGE	METHODS OF ADMINISTRATION	TIME OF DAY TO BE TAKEN

Diagnosis or reason for medication: ____________________

If given PRN, specify the length of time between doses and signs of when to give: ____________________

____

Possible side effects of medication: ____________________

Emergency procedure in case of serious side effects: ____________________

**Note: Auto-Injectable Medications may only be administered to students with potential for severe allergic and/or life-threatening reactions.*

I request and authorize that the above-named student be administered the above identified oral medication in accordance with the instructions indicated above from (date): ____________ to (date): ____________ (not to exceed current school year) as there exists a valid health reason which make administration of the medication advisable during school hours.

LHP's Signature: ____________________ Date: ____________

LHP's Name: ____________________ Phone Number: (_____)____________

LHP's Address: ____________________ Fax Number: (_____)____________

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PARENT/GUARDIAN PERMISSION

The medication is to be furnished by me in the original container, labeled by the pharmacy with the name of the medicine, amount to be taken, and the time of day to be taken. The licensed health professional's name is on the label. I understand that my signature indicates my understanding that reasonable care will be exercised in administration of the medication. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the licensed health professional's directions. If medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.

Signature of Parent/Guardian ____________________ Date ____________

This authorization is good for the current school year only