Dear Parents,

Outdoor Education camp is January 29 – February 1, 2019. Attached is the *Medical Information Sheet* as well as one copy of Form 157 (*Medication at School*). If your child needs to take **any** medication, you will need to have 157 Part A signed by your doctor, and you will need to sign Part B.

This form will be required not only for **prescription medication**, but also for **any over the counter medication**. This may include an occasional aspirin, tylenol or benedryl.

Form 157 authorizes the South Colby staff to administer those specific medications to your child at camp. **YOU WILL NEED A FORM FOR EVERY CONTAINER OF MEDICATION BEING SENT WITH YOUR CHILD TO CAMP.** Please call or send a note with your child and we will be glad to send more forms home. **You must have the medication form completed by your doctor. Without this form we cannot administer *any* medication (prescription or over the counter), so please make these arrangements well in advance.** All medications will be in the possession of adults at all times.

Form 157 (Medication at School) is due no later than **January 18, 2019**.
Please contact us if you have any questions.

SOUTH COLBY ELEMENTARY SCHOOL
South Kitsap School District #402
Outdoor Education Program

PLEASE COMPLETE AND RETURN

STUDENT FORM

Medical Information Sheet:
(CONFIDENTIAL INFORMATION)

Dear Parents:

Will you please give us the following health information about your child, **(Name)**________________________ so we will be informed about any potential health problem while your child is in attendance at the YMCA Camp Seymour Outdoor Education Program.

1. Parents will be notified immediately of any illness or accident to children and care will be given in accordance with parent wishes. Please list phone numbers where a parent can be reached both at home and at work.

(hm#):____________________

(wk#):____________________ (cell#):____________________

2. What is the name and telephone number of your child's physician?

Physician:______________________________

Phone#:____________________

3. Child's birth date: Month_____Day_____Year_____.

4. Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity?__________. If yes, please explain:

5. Does your child have any allergies such as bee stings, asthma, etc.?________. If yes, please explain:

6. Does your child have diabetes?________. If yes, what care of diet, etc. must be taken?

-over-

7. Does your child have epilepsy?________. If yes, what care should be taken at camp?

8. Does your child have hemophilia (tendency to profuse bleeding)___________?

9. Does your child suffer from frequent headaches (migraine)?______________If yes, what care should be taken?

10. Does your child have any allergies to medicines (sulfa, penicillin, etc.)?________. If yes, please specify:

11. Will it be necessary for your child to take any over the counter or prescribed medication while on our Outdoor Education Program?________. If yes, attached is an "Administration of Medication" form. If the medication **is over the counter or prescribed** by a physician, it **MUST** be signed by the doctor. Parents must fill out Part B whether medication is prescribed or over the counter. All medication must be in the original bottle. **PLEASE FILL OUT THOROUGHLY.**

12. Does your child sleep walk, wet the bed, etc.?________If yes, please specify,

13. Has your child been exposed to any communicable disease within the past 21 days?_______

    If yes, which one?_______________

14. Has your child had a tetanus shot?________If yes, what is the date?_____________.

15. Other information you think we should know.

16. Insurance Carrier:___________________________________Policy or Group #:_____________________

In the event that emergency medical treatment is required and you can not be reached, your signature below is authorization for school personnel to obtain emergency care at the nearest medical facility. The expense of the treatment will remain with the child's family.

Date:__________

Signature:_____________________________

Relationship to child: _____________________________

SOUTH KITSAP
SCHOOL DISTRICT

Nurturing Growth • Inspiring Achievement • Building Community

SCHOOL YEAR________

FORM 157

MEDICATION AT SCHOOL

ONE Medication per Form

In order for children to receive medicine while at school, the following form (both parts A and B) must be completely filled out and returned to the school prior to its administration.

A. HEALTH CARE PROVIDER'S/DENTIST'S ORDER FOR MEDICATION AT SCHOOL

I request the following student to be given medication at school because I believe there exists a valid health reason which makes the administration of medication advisable during the time a student is under supervision of school officials.

Student's Name | Grade | Date of Birth | School

Medication To Be Administered | Dosage and Mode of Administration

Condition Being Treated | Time To Be Given at School

Inclusive Dates During Which Medication Is To Be Given

Side Effects of Drug To Be Expected, If Any. *(What emergency measures should be taken if this occurs?)*

Health Care Provider's Name *(Printed)* | Health Care Provider's Signature

Health Care Provider's Phone | Date

B. PARENT'S REQUEST FOR GIVING MEDICATION AT SCHOOL

I request that the principal or a designated staff member give my child, ________________, the medication prescribed by our health care provider, ________________.

The medication is to be furnished by me and is to be in the original container from the pharmacy with the label intact, and the District shall administer such medication as per District policy and procedure.

I will notify school by phone or in person if medication is to be stopped.

I understand that my signature on this form constitutes a waiver for any liability that may occur in the administering of this medicine at school.

ON HALF DAYS OF SCHOOL *(check one)*:

☐ I **do** want the school to administer medication.

☐ I **do not** want the school to administer medication.

Signature of Parent or Guardian | Date

Address | Work Phone | Home Phone

Military Sponsor's I.D. number, if applicable

This request will expire on August 31 of the current school year