THIS PAGE REQUIRED

Medical Information

Please complete all blanks carefully. This information will be treated as confidential. If there is a change in your child's health status after the forms have been turned in, or you need to provide additional information about your child, please attach a separate sheet or notify the Outdoor School Nurse at 410-857-7932.

Name of child: _____ **Birthdate:** _____

Name of healthcare provider: _____ **Phone # of healthcare provider:** _____

To provide the best care for your child and to protect him/her from embarrassment, please check the appropriate response. Please explain any "yes" answers.

Does your child:

1. Yes ☐ No ☐ Need to follow a program of limited activity**?**
   - Explain _____
2. Yes ☐ No ☐ Have any nervous habits, fears or behaviors?
   - Explain _____
3. Yes ☐ No ☐ Have allergies to medications? - Name of medication _____
   - Type of reaction_____
4. Yes ☐ No ☐ Have allergies to insect bites?
   - Is the reaction? Mild ☐ **OR** Severe ☐
   - Medication given _____
   - Explain type of reaction _____
5. Yes ☐ No ☐ Have allergies to plant poisons (i.e.: poison ivy, poison oak, etc.)
   - Is the reaction? Mild ☐ **OR** Severe ☐
   - Medication given _____
   - Explain type of reaction _____
6. Yes ☐ No ☐ Have allergic reactions or intolerances to foods?
   - What foods? _____
   - Ingestion ☐ Contact ☐ Air ☐
   - Is the reaction? Mild ☐ **OR** Severe ☐
   - Medication given _____
   - Explain type of reaction _____
7. Yes ☐ No ☐ Have dietary restrictions based on health or religious practices?
   - Explain _____
8. Yes ☐ No ☐ Have seizures - Type? _____
   - If "yes", date of last seizure _____
9. Yes ☐ No ☐ Wet the bed? – How Often? _____
10. Yes ☐ No ☐ Sleepwalk? – How Often? _____
11. Yes ☐ No ☐ Have asthma? – Comments _____
    - If "yes", does he/she use an inhaler? Yes ☐ No ☐
12. Yes ☐ No ☐ Have any other chronic health conditions or syndromes?
    - Explain _____
13. Yes ☐ No ☐ Take daily medication?
    - Comments _____

****If "Yes", medication consent **MUST BE** properly filled out. (please see next page)*

14. Yes ☐ No ☐ Need assistance with going to the restroom, changing their clothes, and/or showering?
    - Comments _____

****THIS PAGE REQUIRED*****

Medication Consent

Name of child: _____ Birthdate: _____ Allergies: _____

Students may complain of mild pain, rash, indigestion or stomach ache during Outdoor School. Tylenol, Benadryl, Motrin, and Tums may be given on an "as needed" basis with your permission(per CCPS nursing protocol). ***We have the medications listed below.***
Please check the medications that you are allowing us to administer:

- **FOR MILD PAIN:** Acetaminophen/Tylenol ☐ Ibuprofen/Motrin ☐
- **FOR RASHES:** Calamine lotion ☐ Diphenhydramine/Benadryl ☐
- **FOR INDIGESTION AND STOMACH ACHE:** Tums ☐

☐ **I do not wish for my child to receive any of these medications.**

Comments:
_____

Parent Permission to Administer Medications:
I authorize and request representatives of the Outdoor School to administer the medications listed above which are approved for Outdoor School use and in doing so, relieve them of any responsibility for ill effects from said administration to my child.

- **Signature of Parent/Guardian:** _____
  (required for Outdoor School staff to give medications listed above)

Instructions regarding prescription and over the counter medications to be given at Outdoor School:

All medications, prescription and over the counter require a healthcare provider's order. (This includes vitamins and homeopathic/herbal medications) No **medications will be given without an order.**
Medications sent to Outdoor School must be in the original prescription bottle or package, labeled specifically for the student. The prescription label on the medication must match the authorized prescriber's order.
Unlabeled or improperly labeled medications will not be given.
Medications are to be placed in a bag clearly marked with the student's name and turned in to the home school nurse.
Send only enough medication for the week.
The medication containers and unused medications will be returned to the home school nurse and can be picked up when your child returns home from Outdoor School.
Please do not send any medications in the student's luggage. Students may not transport their own medications.

THIS PAGE REQUIRED FOR STUDENTS RECEIVING ANY MEDICATION

Carroll County Outdoor School Medication Form

This form is to be completed and signed by the authorized prescriber and signed by a parent/guardian for all medications to be given at Outdoor School. This includes both prescription and over the counter medications, except those listed on the previous page. **All medications and orders on file at your child's school will be forwarded to Outdoor School for the week they will be attending.**

Student Name: ____ D.O.B.:__________ Allergies: ________________________

Medication: _____________________________ Route: _________________ Strength: ___________ Dosage: ____________

Time to be given: __________ Reason: __________________________________ Side Effects: __________________________

Time	Monday - _____	Tuesday - _____	Wednesday - _____	Thursday - _____	Friday - _____

Medication: _____________________________ Route: _________________ Strength: ___________ Dosage: ___________

Time to be given: __________ Reason: __________________________________ Side Effects: ________________________

Time	Monday - _____	Tuesday - _____	Wednesday - _____	Thursday - _____	Friday - _____

Medication: _____________________________ Route: _________________ Strength: ___________ Dosage: ___________

Time to be given: __________ Reason: __________________________________ Side Effects: ________________________

Time	Monday - _____	Tuesday - _____	Wednesday - _____	Thursday - _____	Friday - _____

Parent/Guardian Signature: _____________________________ Healthcare Provider Name: ___________________________

Healthcare Provider Phone #: ___________________________ Healthcare Provider Signature: ________________________

____________________________________	________	____________________________________	________
____________________________________	________	____________________________________	________
Nurse Signature	Initials	Nurse Signature	Initials