Edmonds SCHOOL DISTRICT
Each student learning, every day!

SS 505

EDMONDS SCHOOL DISTRICT
Health Form for Camps and Outdoor School

Student's Name _____ Parent/Guardian_____

Address_____

Day Phone (_____) _____ Cell Phone (_____) _____

Emergency Contact _____ Relationship _____

Day Phone (_____) _____ Cell Phone (_____) _____

Check if your child has any of the following conditions:

☐ Asthma	☐ Food/Medicine Allergies	☐ Heart Problems	☐ Seizure
☐ Bed Wetting	☐ Hay Fever	☐ Insect Sting Allergy	☐ Sleep Walking
☐ Diabetes	☐ Hearing Loss	☐ Menstrual Disorders	☐ Vision Loss

☐ Other _____

Health Insurance Provider: _____ Policy/Group #: _____

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, he/she needs to stay home.

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 side of this form. Contact your licensed health professional to complete his/her section of the medication form before returning it to school.

My child may self-administer (please check) 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
Each student learning, every day!

SS 505

EDMONDS SCHOOL DISTRICT

Authorization for Administration of Medication for Camps and Outdoor 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 Care Professional (LHCP) (e.g., MD, DO, ARNP, DDS, etc.)

Diagnosis	Medication	Dosage	Route	Time/Interval Condition/Symptom	Self-Carry*	Side Effects
					Y N	
					Y N	
					Y N	
					Y N	
					Y N	
					Y N	
					Y N	

***Marking "yes" to self-carrying indicates that the LHCP has provided instruction in the purpose and appropriate method/frequency of use, and that the student is capable and safe to self-carry and administer.**

I request and authorize that the above-named student receive the above identified medications in accordance with the instructions indicated beginning ____/____/____ to not to exceed current school year or ____/____/____.

LCHP's Signature: _____ Date: _____

LCHP's Name: _____ Phone Number: (_____) _____

LCHP's Address: _____ Fax Number: (_____) _____

SECTION CAN ONLY BE COMPLETED BY A HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY

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. 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: _____

Student Signature (Self-Carrying):_____ Date: _____

Nurse Signature: _____ Date: _____