MESD OUTDOOR SCHOOL
11611 NE Ainsworth Circle
Portland, OR 97220
Phone: 503-257-1600 / FAX: 503-257-1592

Teacher_____
School_____
Week_____
Site Attending_____

STUDENT HEALTH HISTORY FORM FOR OUTDOOR SCHOOL AND COMPANION PROGRAMS (Please Print)

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

In order for your child to attend Outdoor School, *all information* on this form must be completed. If your child's condition changes after you submit this form, please send a note to the Outdoor School nurse.

Student's Full Name _____Birth Date_____ Age_____ Sex_____

Parent's Name _____ Home Phone_____ Cell Phone_____

Parent's Name _____ Home Phone_____ Cell Phone_____

Parent's Work Phone_____ Parent's Work Phone_____

Student's Address_____ City_____Zip _____

Family Doctor_____Phone_____

Emergency Contact #1 _____Relationship_____ Phone_____

Emergency Contact #2 _____ Relationship_____ Phone_____

	ALLERGIES (*please list below)		Mobility Issues
	Asthma or other breathing problems		Physical Injuries (recent)
	Bowel / Bladder Problems		Seizure Disorder
	Bedwetting		Skin Problems
	Diabetes		Sleep Walking
	Emotional/behavioral or learning concerns		Vision Problems
	Hay Fever		Other chronic or recent illness or surgical procedures (specify):
	Hearing Problem		
	Heart Problem		

*Please provide more specific information about identified health concern including treatment needed while at Outdoor School:

_____

_____

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.):_____

_____

Legal parents/guardian are contacted first whenever possible.

In case of medical or surgical emergency, I hereby give permission to the Outdoor School 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** _____

THIS PAGE FOR OUTDOOR SCHOOL NURSE USE ONLY

RECORD OF MEDICATIONS ADMINISTERED BY THE OUTDOOR SCHOOL NURSE

STUDENT NAME:_____

SCHOOL_____**DATES ATTENDING**_____

Initials	Signature	Initials	Signature

Use the following key for days medication not given: **X** = Not at site **0** = Student refuses/parent notified
Self-administration key: **SA** = Self-Administration **NS** = No Show
(Please: use **one line only per dose** administered) (initial each entry)

Count In/# Initial	Count Out/# Initial	Medication Name and Dose	Hour	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.

Medication Record (As needed medications sent from home.)
(Please: use **one line only per dose** administered)

Date	Time	Medication, route, dosage, reason	Initials

IF YOUR CHILD WILL NEED MEDICATION WHILE AT OUTDOOR SCHOOL, PLEASE READ AND COMPLETE THE INFORMATION BELOW AND ON PAGE 3.

MEDICATION RULES

1. All medication must be maintained and administered by the nurse. Medications include prescription, over-the-counter and vitamins/supplements. Students are not allowed to carry their own medication. Some exceptions are made for emergency asthma inhalers and auto injectors for severe allergic reactions.

2. Any prescription, over-the-counter medication or vitamin/supplement must have the following:
   - **Parent must sign the authorization on page 3.**
   - Parent must include the following:
     - **Name** of medication
     - **Dose** (strength and how much) of medication
     - **Time 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 medication will be accepted or given if they are sent to Outdoor School in unapproved containers (i.e., envelopes, baggies, pill planners etc.)**
   - Prescription medication must have an accurate label. **This includes samples given by physician. If the directions on the prescription label are different from what the physician is currently prescribing, written instruction is required from the physician. This also includes directions for over-the-counter medications.** See "Physician Directions" on the next page.
   - **All inhalers must be appropriately labeled with their prescription.**

   - **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 emergency inhaler and/or auto injector and directions: _____

Your child must be developmentally and behaviorally able to carry and self administer their inhaler and/or auto injector.

3. **All vitamins/supplements require 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, probiotics, daily vitamins, 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.

TEACHER _____ STUDENT'S FULL NAME _____

PARENT/GUARDIAN AUTHORIZATION FOR OUTDOOR SCHOOL NURSE TO ADMINISTER MEDICATIONS.
(Prescription, Over-the-Counter, Vitamins/Supplements)

I am requesting that my child, _____, be given or be assisted in taking:

Name Of Medication	Dosage (amount)	Time(s) To Be Given If once daily, specify am or pm.	Dates To Be Given	Purpose Of Medication

Parent /Guardian Signature ☒ _____ Date:_____

(This authorization applies only to the medication listed above and for the duration of treatment or week. This also authorizes an exchange of information, as necessary, between the nurse, appropriate school personnel, my child's health provider, and/or my child's pharmacist.

PHYSICIAN DIRECTION

(required in writing IF the prescription label does not match parent direction above)

- ☐ **Special instructions including adverse reactions and action required:**_____

_____

_____ _____ _____

Physician's Name (print or stamp) **Physician's Signature** **Date**

_____ _____ _____

Address **Zip Code** **Phone**