**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_____ Gender _____

Parent's Name _____ Cell Phone_____ Alternate Phone(home/work)_____

Parent's Name _____ Cell Phone_____ Alternate Phone(home/work)_____

Student's Address_____ City_____Zip _____

Health Care Provider_____Phone_____

Emergency Contact #1 _____Relationship_____ Phone_____

Emergency Contact #2 _____ Relationship_____ Phone_____

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

*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 (examples: vegetarian, vegan, gluten free, Halal, Kosher) etc: _____

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:

_____

### Legal parents/guardian are contacted first whenever possible.

Is your student currently receiving mental health services? _____ If yes, who is the Provider? Name _____
Phone Number _____ May we contact them in a mental health emergency? _____

Other pertinent health information or safety concerns: _____

Other needs we should know about (privacy needs, anxiety/nervousness, etc.):_____

_____

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 Health Care Provider.

Legal Parent's or Guardian's Signature: ☒ _____ Date_____

Child's Insurance Information_____

**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 |
|---|---|---|---|
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**Use the following key for days medication not given:** **X** = Not at site **0** = Student refuses/parent notified
**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. |
|---|---|---|---|---|---|---|---|---|---|
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**Medication Record (As needed medications.)**
(Please: use **one line only per dose** administered)

| Date | Time | Medication, route, dosage, reason | Initials |
|---|---|---|---|
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IF YOUR CHILD WILL NEED MEDICATION WHILE AT OUTDOOR SCHOOL, PLEASE READ AND COMPLETE THE INFORMATION BELOW AND ON PAGE 3.

**Outdoor School does not supply over-the-counter medicine; it needs to be brought from home.**

## 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 health care provider. If the directions on the prescription label are different from what the health care provider is currently prescribing, written instruction is required from the health care provider. This also includes directions for over-the-counter medications.** See "Health Care Provider 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: _____**

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**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) Please note that Outdoor School does not supply over-the-counter medicine.

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 |
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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.

## HEALTH CARE PROVIDER (HCP) DIRECTION

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

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

_____

_____ _____ _____

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

_____ _____ _____

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