School: _____ Updated July 23 2019

McDowell Environmental Center

STUDENT HEALTH FORM

All information is confidential. **PLEASE PRINT NEATLY!**

This form must be filled out by the student's **PARENT or LEGAL GUARDIAN!**

Student name: (Last) (First) (Middle)		Date of Birth:	Sex:
Age: Grade: Height/Weight:		Preferred name (if different from above):	
Address: City: State: Zip Code:			
Parent/Guardian name: (Last) (First)		Relationship to student:	
Cell Phone:	Work Phone:	Email Address:	
Other Emergency Contact: (Last) (First)		Relationship to student/Phone Number:	
Primary Physician:		Physician Phone:	

Is student on a special diet? Y / N If so, please explain what they CAN eat as well as what they CANNOT eat:

_____

_____

****If special foods must be sent with your child,**
please contact the camp nurse at 205-387-1806 ext. 125 or rn@campmcdowell.com**

ALLERGY INFORMATION

To the best of your knowledge does your child have any allergies? **YES / NO** (Please circle one)
If YES was circled, please indicate to which of the following your child is allergic. Please be specific:

FOODS:	
PLANTS:	
MEDICINE ALLERGIES:	
ANIMALS:	
INSECTS:	
OTHER:	

Please indicate what treatment your child should receive if exposure occurs (Any medications to which your child is allergic will NOT be given):

_____

**** If your child is bringing an EPI-PEN,**
you MUST contact the camp nurse at 205-387-1806 ext. 125 or rn@campmcdowell.com**

ADDITIONAL HEALTH CONCERNS: _____

_____

PLEASE READ, COMPLETE and SIGN **PAGE 2** OF THIS FORM!!

STUDENT MEDICATIONS WHILE at MCDOWELL ENVIRONMENTAL CENTER:

- All medications must be in their original container with the student's name and school written on the container.
- There must be clear directions on when &/or why to give the medication.
  - NOTE: "Give as Directed" is not acceptable
- The container must specify the strength and dose of the medication.
- If it is an Over-The-Counter medication it must be age-appropriate and will be given following manufacturer recommendations. If it is not recommended for your child's age and your child's Healthcare provider prescribed it then a note from that provider must be sent with the OTC medication.

PRESCRIPTION MEDICATIONS:

ALL MEDICATION IS ADMINISTERED BY A LICENSED NURSE, EMT OR AUTHORIZED SCHOOL PERSONNEL. Add additional sheet, if necessary.

List all prescription medications that you will send with your child. Circle the time(s) to administer this medicine to the child, choosing from the following: **B*=** Before Breakfast, **B=** After Breakfast, **L=** After Lunch, **C**=Canteen (4PM), **D=** After Dinner, **HS=** At Bedtime
*If a time is not selected, medicines will be given after breakfast.

Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS**
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OVER THE COUNTER (OTC) MEDICATIONS:

ALL OTC MEDICATIONS MUST BE PROVIDED BY PARENTS/LEGAL GUARDIANS OF THE STUDENT.
Circle "As Needed Only", if medication is not taken daily.

Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**

In the event of unexpected illnesses, our Nurse/EMT will have limited OTC medicines available for your child–
Which of the following medicines do you permit to be given to your child by our Nurse/EMT?
Ibuprofen: Yes__ No__ **Acetaminophen:** Yes__ No__ **Benadryl:** Yes__ No__ **Cough Drops:** Yes__ No__ **Tums:** Yes__ No__

PHOTO RELEASE

"I give my permission for any photos or videos taken of my child or any artwork and writing made by my child during educational programs at Camp McDowell to be used for the public relations of the program." (Please note if you DO NOT give photo release permission)

MEDICAL AUTHORIZATION AND RELEASE

"I AUTHORIZE THE NURSE, AUTHORIZED SCHOOL PERSONNEL, OR AUTHORIZED CAMP STAFF THE TASK OF ASSISTING MY CHILD IN TAKING THE ABOVE MEDICATIONS.I GIVE THE NURSE PERMISSION TO SPEAK WITH MY CHILD'S HEALTH CARE PROVIDER OR PHARMACIST AND AUTHORIZE MY CHILD'S HEALTH CARE PROVIDER OR PHARMACIST TO SPEAK WITH THE NURSE SHOULD A QUESTION COME UP ABOUT ONE OF MY CHILD'S MEDICATIONS.
ALL HEALTH INFORMATION IS CONSIDERED CONFIDENTIAL AND WILL BE SHARED ONLY ON A NEED-TO-KNOW BASIS TO ENSURE THE SAFETY OF YOUR CHILD. I ALSO UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL MEDICAL TREATMENT AND OTHER HEALTH CARE SERVICES PROVIDED TO MY CHILD."

"This is to certify that the information provided on this form is accurate to the best of my knowledge,"

_____ _____

SIGNATURE of PARENT or LEGAL GUARDIAN **DATE**