MEDICATION ADMINISTRATION AT CAMP

Dear Parent/Guardian:

If your child takes routine prescription medication, or you are authorizing the administration of "over the counter" medications while at camp, the medication form must be completed in order for the medication to be administered. The parent/guardian signature and physician's signature are required. **If the medication is not listed on the school medication form, it may not be administered to your child on the trip.**

Any medication given to your child at school will require the extended field trip medication authorization form to be filled out and signed by you and your doctor. We cannot administer any medications your child takes at school with the form we have at school.

Any medication sent with your child must be in the container in which it was purchased and labeled with the student's name with dispensing instructions on the form. **As things are very hectic the morning of the trip, please be sure all forms are completed and questions answered prior to departure in the morning.**

Thank you,
Jennifer Partmann, R.N., M.A.

ADMINISTRACION DE MEDICAMENTOS EN EL CAMPAMENTO

Estimado Padre/Guardián:

Si su niño/a toma medicamentos prescriptos de rutina, o si usted está autorizando darle medicamentos "que se compran sin receta" mientras está en el campamento, la forma para el medicamento debe llenarse para poder administrarle estos. La firma del padre/guardián y del doctor es requerida. **Si el medicamento no está en la lista en la forma de medicamento de la escuela, puede que no sea administrada a su niño/a durante el viaje.**

Todo medicamento enviado con su niño debe estar en el frasco en que fue comprado y con una etiqueta con el nombre del estudiante con instrucciones para dispensarla en la forma. **Como las cosas son complicadas la mañana del viaje, por favor esté seguro que todas las formas estén completas y las preguntas respondidas antes de la salida en la mañana.**

Gracias,

Jennifer Partmann, R.N., M.A.

Health History /Emergency Treatment Form
The Outdoor School at Rancho Alegre

Complete and return to your classroom teacher before leaving for The Outdoor School. Any changes to this form should be provided in writing to the classroom teacher before arrival at The Outdoor School.

The Outdoor School at Rancho Alegre is owned/operated by Los Padres Council, BSA.

Student Name:_____ Birth date:___/___/___ Sex___ Age ___
Home address:_____Home Phone ( )_____
City, State, Zip_____
School:_____ Entering _____ grade in fall 2005

Emergency Numbers (fill in *completely*):

1. Custodial parent/guardian:_____
Cell: ( )_____ Day phone: ( )_____Night phone: ( ) _____

2. Second parent/guardian:_____
Cell: ( ) _____ Day phone: ( )_____ Night phone: ( ) _____

3. Emergency contact/relative:_____
Day phone: ( )_____Night phone: ( ) _____

4. Neighbor:_____
Day phone: ( )_____Night phone: ( ) _____

INSURANCE INFORMATION

Is the student covered by family medical/hospital insurance? ☐ Yes ☐ No
If so, indicate carrier or plan name_____Group #_____ Family Doctor_____Phone ( )_____

AUTHORIZATION AND CONSENT FOR MINOR

Pursuant to California Civil Code Section 25.8, Pursuant to California Penal Code Section 12552

With the understanding that my child, _____, will be at all times under the supervision of a certified teacher, I give my permission for him/her to attend The Outdoor School and to participate in all the activities involved, unless otherwise noted.

The undersigned do hereby authorize The Outdoor School, its employees, agents and volunteers as agent for the undersigned to consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for: _____born on _____, which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provisions of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, camp, or elsewhere. This authorization will remain effective while the above minor is en route to and from or involved or participating in any activity of The Outdoor School, unless revoked by the undersigned, in writing, delivered to The Outdoor School.

I hereby assign and grant The Outdoor School the right and permission to use and publish photographs/film/videotapes/electronic representations and/or sound recordings made of my son/daughter during the week. I release The Outdoor School from any and all liability from such use and publication and waive any right to any compensation.

Student Name_____ **Address**_____
X_____ **Date** _____ **Telephones: Home ( )**_____ **Business( )**_____
Signature of Parent and/ or Guardian
X_____
Witness (Other than Parents) signature
Witness address_____**Telephones: Home ( )**_____ **Business ( )**_____

**If for religious reasons, medical/surgical attention cannot be given strike out that portion of the consent form.*

MEDICATIONS BEING TAKEN: All medications must be approved by the school district and are regulated by school district policy not The Outdoor School. Please contact your school for the appropriate forms.

HEALTH HISTORY: (Please circle yes or no; provide comments regarding management of condition where applicable)

Yes No 1. Severe Bee Sting Allergies ☐ Yes ☐ No
Date of last reaction and its severity:_____
(If bee sting kit is necessary, please use school district medication form)

Yes No 2. Allergies- Hayfever, Food, Other
Comments: _____

Yes No 3. Asthma (Include date of last attack)
Comments: _____
Will your child be bringing an inhaler? ☐ Yes ☐ No

Yes No 4. Heart Condition Comments: _____

Yes No 5. Diabetes Comments:_____

Yes No 6. Epilepsy: (Include date of last seizure)
Comments: _____

Yes No 7. Frequent Severe Headaches or Fainting
Comments: _____

Yes No 8. Any _____Speech, _____Hearing, or _____Vision problems
Comments: _____

Yes No 9. Sleepwalking. How often?_____

Yes No 10. Prone to bedwetting? Frequency? _____
Date of Last Tetanus: _____

ALLERGIES/RESTRICTIONS: List all known. Describe reaction and management of the reaction.
Medical Allergies (list):_____
_____
_____
Food Allergies (please include restrictions, i.e. vegetarian, vegan): _____
_____
_____
Activity Restrictions (e.g. what cannot be done, what adaptations or limitations are necessary): ____
_____
_____
Please use this space to provide any additional information about student's behavior and physical, emotional, or mental health about which we should be
aware._____
_____
_____

EXTENDED FIELD TRIP OR EXCURSION MEDICATION(S) AUTHORIZATION

(Use as many forms as necessary)

Valid only for field trip or excursion to ______________________________.

EXCEPTION: California Education Code 49423.5 - Specialized services, i.e., EpiPen, diabetes care, nebulizer, etc., may require additional forms and instructions signed by Parent or Legal Guardian and Physician. Request specialized services forms from school.

Please review the **'Notice of Provisions' California Education Code (CEC) Sections 49423, 49423.5, 49480 and California Administrative Code (CAC) Title 5, 18170,** printed on the reverse side of this form.

PARENT OR LEGAL GUARDIAN

Part 1: To be completed by Parent or Legal Guardian

NOTE: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of Physician.

I request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the-counter medication). I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I understand that my child may not have nor take medication during this field trip or extended excursion unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's Physician and counsel school personnel as needed with regard to this medication.

______________________ M F ____________ ______________________

Child's Name | Sex | Birthdate | Address

______________________ ______________________

Name of School | Teacher

List all medications routinely taken other than those listed below on this form. ______________________

I have read and understand the 'Notice of Provisions' printed on the reverse side of this form pertaining to **'Extended Field Trip or Excursion Medication(s) Authorization.'**

__________ X______________________ (___)__________ (___)__________ (___)__________

Date | **Signature** Parent or Legal Guardian | Home Telephone | Work Telephone | Cell #/Pager #

PHYSICIAN

Part 2: To be completed by the Physician

The child named above is under my care. It is necessary for him or her to receive the following medication(s), prescribed and/or over the counter, during the extended field trip or excursion.

Name of medication ______________________
Diagnosis ______________________ Dosage (be specific, i.e., milligrams, etc.) ______________
Time of day to be given ______________________ Frequency and Indication if 'as needed' ______________
Method of administration______________________ Duration ______________
Precautions or side effects ______________________
Special instructions, ie. storage/handling ______________________

- - - - - - - - - - - - - - - - - - - -

Name of medication ______________________
Diagnosis ______________________ Dosage (be specific, i.e., milligrams, etc.) ______________
Time of day to be given ______________________ Frequency and Indication if 'as needed' ______________
Method of administration______________________ Duration ______________
Precautions or side effects ______________________
Special instructions, ie. storage/handling ______________________

- - - - - - - - - - - - - - - - - - - -

Name of medication ______________________
Diagnosis ______________________ Dosage (be specific, i.e., milligrams, etc.) ______________
Time of day to be given ______________________ Frequency and Indication if 'as needed' ______________
Method of administration______________________ Duration ______________
Precautions or side effects ______________________
Special instructions, ie. storage/handling ______________________

- - - - - - - - - - - - - - - - - - - -

Name of medication ______________________
Diagnosis ______________________ Dosage (be specific, i.e., milligrams, etc.) ______________
Time of day to be given ______________________ Frequency and Indication if 'as needed' ______________
Method of administration______________________ Duration ______________
Precautions or side effects ______________________
Special instructions, ie. storage/handling ______________________

X______________________ ______________________ __________

Signature Physician | Please print name | Date

(___)______________________

Office Telephone

The child named above is under my care. It is necessary for him or her to receive the following medication(s), prescribed and/or over the counter, during the extended field trip or excursion.

Name of medication ______
Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

Name of medication ______
Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

PHYSICIAN

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Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

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Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

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Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

Name of medication ______
Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

PHYSICIAN

Name of medication ______
Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

Name of medication ______
Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

X ______ ______ ______
Signature Physician | Please print name | Date

(______) ______
Office Telephone

AUTORIZACION PARA EXCURSION Y PASEO EXTENDIDO Y MEDICAMENTO(S)
(Cuantas formas sean necesarias)

Valida únicamente por excursión o paseo a ______________________________

Excepción: Código Educativo de California 49423.5, Puede que para los servicios especializados tales como "Epi Pen", medico por diabetes, nebulizador, etc., sean necesarios unos formularios y instrucciones adicionales firmados por los padres o un guardián legal mas un medico. Usted puede pedir los Formularios para servicios especializados de la escuela.

Favor de repasar el 'Aviso Sobre las Estipulaciones' Código Educativo de California (CEC) Artículos 49423, 49423.5, 49480, que se haya impreso al otro lado de este formulario.

Aviso: Todos los medicamentos tienen que venir acompañados con receta, incluso los medicamentos que se pueden comprar sin receta. Los medicamentos deben estere en su recipiente/frasco original y la etiqueta debe llevar el nombre del niño o niña, el nombre del medicamento, el dosis, la forma de administración, el horario de tomar medicinas y el nombre de el/la Médico.

PADRE, MADRE O GRARDIÁN LEGAL

Parte 1: Debe completar esta parte el Padre, La Madre o el/la Guardián Legal

______________________________ M F ______________________________
Nombre de Niño(a) o Niño(a) de la Corte — Sexo — Domicilio

______________________________ ______________________________
Nombre de la Escuela — Maestro/Maestra

Solicito que miembros del personal escolar designados asisten a mi hijo/hija a tomar este medicamento recetado (a incluir medicamentos recetados del tipo que normalmente no requieren receta.) Consiento en y por este medico dejo a salvo al Distrito y sus empleados de cualquier y todas las reclamaciones, demandas, causes de acción, responsabilidad o perdida de cualquier tipo debido o como resultado de actos o omisiones con respeto a este medicamento. Entiendo que mi hijo/hija no puede ni tener ni tomar medicamentos durante esta excursión y paseo si no se llenen todos los requisitos. Por este medio otorgo mi consentimiento a que se comunique un/una enfermera escolar con el/la Medico de mi hijo/hija, y a que se aconseja el personal escolar tocante este medicamento como sea necesario.

Apunte todos los medicamentos que se tomen con regularidad excepción de la lista abajo en esta forma.______________________________

He leído y entiendo el "Aviso Sobre las Disposiciones" que se halla impreso al otro lado de este formulario tocante la autorización para excursión y paseo y autorización para tratamiento medico

______________________________ ______________________________
Firma de el Padre, la Madre o el/la Guardián Legal — Fecha

______________________________ ______________________________ ______________________________
Teléfono del Hogar — Teléfono de Trabajo — Número De Celular o Biper

PHYSICIAN

Part 2: To be completed by the Physician

The child named above is under my care. It is necessary for him or her to receive the following medication(s), prescribed and/or over the counter, during the extended field trip or excursion.

Name of Medication ______________________________
Diagnosis ______________________________
Dosage (be specific, i.e., milligrams etc.) ______________________________
Time of day to be given ______________________________
Frequency and Indication if "as needed" ______________________________
Method of administration ______________________________
Duration ______________________________
Precautions or side effects ______________________________
Special instructions, i.e. storage/handling ______________________________

Name of Medication ______________________________
Diagnosis ______________________________
Dosage (be specific, i.e., milligrams etc.) ______________________________
Time of day to be given ______________________________
Frequency and Indication if "as needed" ______________________________
Method of administration ______________________________
Duration ______________________________
Precautions or side effects ______________________________
Special instructions, i.e. storage/handling ______________________________

Name of Medication ______________________________
Diagnosis ______________________________
Dosage (be specific, i.e., milligrams etc.) ______________________________
Time of day to be given ______________________________
Frequency and Indication if "as needed" ______________________________
Method of administration ______________________________
Duration ______________________________
Precautions or side effects ______________________________
Special instructions, i.e. storage/handling ______________________________

______________________________ ______________________________
Signature Physician — Date

______________________________ ______________________________
Name of Physician (Please print) — Office Telephone

Part 2: To be completed by the Physician

The child named above is under my care. It is necessary for him or her to receive the following medication(s), prescribed and/or over the counter, during the extended field trip or excursion.

PHYSICIAN

Name of Medication ______________________________

Diagnosis ______________________ Dosage (be specific, i.e., milligrams etc.) __________

Time of day to be given ______________________ Frequency and Indication if "as needed" __________

Method of administration ______________________ Duration ______________________

Precautions or side effects ______________________________

Special instructions, i.e. storage/handling ______________________________

Name of Medication ______________________________

Diagnosis ______________________ Dosage (be specific, i.e., milligrams etc.) __________

Time of day to be given ______________________ Frequency and Indication if "as needed" __________

Method of administration ______________________ Duration ______________________

Precautions or side effects ______________________________

Special instructions, i.e. storage/handling ______________________________

Name of Medication ______________________________

Diagnosis ______________________ Dosage (be specific, i.e., milligrams etc.) __________

Time of day to be given ______________________ Frequency and Indication if "as needed" __________

Method of administration ______________________ Duration ______________________

Precautions or side effects ______________________________

Special instructions, i.e. storage/handling ______________________________

PHYSICIAN

Name of Medication ______________________________

Diagnosis ______________________ Dosage (be specific, i.e., milligrams etc.) __________

Time of day to be given ______________________ Frequency and Indication if "as needed" __________

Method of administration ______________________ Duration ______________________

Precautions or side effects ______________________________

Special instructions, i.e. storage/handling ______________________________

Name of Medication ______________________________

Diagnosis ______________________ Dosage (be specific, i.e., milligrams etc.) __________

Time of day to be given ______________________ Frequency and Indication if "as needed" __________

Method of administration ______________________ Duration ______________________

Precautions or side effects ______________________________

Special instructions, i.e. storage/handling ______________________________

Name of Medication ______________________________

Diagnosis ______________________ Dosage (be specific, i.e., milligrams etc.) __________

Time of day to be given ______________________ Frequency and Indication if "as needed" __________

Method of administration ______________________ Duration ______________________

Precautions or side effects ______________________________

Special instructions, i.e. storage/handling ______________________________

______________________________ ______________

Signature Physician Date

______________________________ ______________

Name of Physician (Please print) Office Telephone