SCHOOL PRESENTLY ATTENDING _____

OUTDOOR EDUCATION LABORATORY SCHOOLS - MEDICAL INFORMATION

Student's Name _____ Height_____ Weight _____
Last First Middle Male _____ Female _____

Birthdate: _____ Age: _____
MM/DD/YYYY

Child Resides With: Both Parents _____Father ____Mother ____Shared households____Other (specify) : _____

Complete Address _____
Number Street Apt # City Zip

Father's Name _____ Mother's Name _____
Father's Home/Cell Phone _____ Mother's Home/Cell Phone _____
Father's Work Phone _____ Mother's Work Phone _____
Father's Email _____ Mother's Email _____

Emergency Contact Name (in case neither parent can be reached):_____
Telephone: _____ Relationship: _____

Name of Child's Physician _____
Address _____
Physician's Phone: Day: _____ Night: _____
Preferred hospital in case of emergency _____

These medications, available at the Lab School, may be administered by the resident Outdoor Education Staff in order to relieve minor pain and discomfort. Circle YES or NO: **Yes** to ALL meds ____ **No** to All Meds ____

Aloe Vera	Yes No	Hydrocortisone Cream 1%	Yes No	Robitussin DM Cough Syrup	Yes No
Benadryl	Yes No	Hydrogen Peroxide [1/2 strength]	Yes No		
Benadryl Cream	Yes No	Imodium	Yes No	Sudafed PE (age 12 & up only)	Yes No
Cough drops/throat lozenges	Yes No	Ibuprofen	Yes No	Sun-Screen	Yes No
		Milk of Magnesia	Yes No	Tums	Yes No
Chlor-Trimeton	Yes No	Neosporin/Antibiotic Ointment	Yes No	Tylenol	Yes No

Please list <u>any and all</u> medications, vitamins, herbs, homeopathic or essential oils that you expect to send with your child:

_____ _____
Name of drug – Reason taking Name of drug – Reason taking

An additional medication form, which must accompany the medication, will be sent home the week prior to Outdoor Lab.

PERMISSION FOR ADMINISTRATION OF MEDICATION AND EMERGENCY CARE

I hereby request and give my permission to the Jefferson County School District R-1 to administer medication to the student identified above. I understand that it is my responsibility to provide medications not listed above. I understand that all medication must be provided in the original pharmacy labeled containers. I understand that my child assumes responsibility for going to the clinic at the specified time(s) for medications. I acknowledge that the administration of this medication by school personnel is an accommodation performed solely upon my request. In consideration of the acceptance of this request, I release and waive any and all claims which I now have or may hereafter have against the Jefferson County School District R-1 and its employees arising out of the administration of or failure to administer the medication to the student or any adverse reaction by the student to the medication.

I understand that if my child requires medical attention, the Lab School staff will attempt to contact me first. If I am unavailable, my child's physician, listed above, will be called. Should I or my physician be unavailable, I hereby authorize any emergency medical treatment that is deemed necessary, or any medical treatment I specifically authorize in advance. I also give permission for school personnel to transport my child or arrange transportation, in an emergency or if medical care is needed.

_____ ___ _____
* **Required** Signature of Parent or Legal Guardian Date

STUDENT'S NAME: _____
Last First Middle

I. Please list any medical condition/concerns, recent injury or hospitalization:_____
_____
_____
II. Please list any activity restrictions/limitations or any assistive device (ie. prosthetic, hearing aid, etc) that will be sent:
_____
III. Does your child have asthma? Yes ___ No ___ Please explain: trigger/frequency/severity/treatment of attacks :
_____
Do you feel your child needs to carry their rescue inhaler with them at all times while at Outdoor Lab? Yes:____No:____
Do you feel your child is responsible enough to carry his/her rescue inhaler once at Outdoor Lab? Yes ___ No___ N/A __

It is recommended that students who will carry an inhaler might want to bring an extra one to be kept in the clinic in the event that your child misplaces their inhaler.

IV. Known allergies: Hayfever ___Bees ____ Food (name food)_____Drug Allergy (name of drug): _____
Other: _____
Explain reaction: _____
If your child has an Epi Pen, has it ever been used: No:_____ Yes:_____ If yes, when:_____
V. Does your child need a special diet? _____ If yes, explain: _____

You may need to furnish food substitutes if your child requires a special diet. We REQUIRE that all food sent DOES NOT contain tree nuts or peanuts - Outdoor Labs are nut free facilities.

Do you need a copy of the menu emailed to you along with instructions about how to send food substitutes? **Yes No**

Please contact the Kitchen Manager and/or Nurse at Mt. Evans (303-982-5208) or Windy Peak (303-982-9494) in advance for further dietary information. (Just rewording of this sentence)The kitchen manager or nurse at Mt. Evans (303-982-5208) or Windy Peak (303-982-9494) may be contacted in advance for dietary information.

VI. Circle any condition needing bottom bunk: Bedwetting____ Frequent urination ____Sleepwalking____ Seizures_____
Restlessness____Other____ Further explanation: _____
VII. Any separation or homesickness issues? If yes, explain: _____
Attach an additional sheet of paper if there is any other information you wish to share relating to your child's well-being.

ACCIDENT INSURANCE COVERAGE INFORMATION

An insurance policy covering accidental injuries to students while at the Outdoor Education Laboratory Schools is provided as part of the student's tuition fee. The policy provides a limited amount of coverage for all or part of the cost of the treatment of accidental injuries, depending on the nature and extent of the injury. Parents are responsible for those portions of medical bills not paid by the insurance company.

PARENTS/GUARDIANS ARE RESPONSIBLE FOR ANY MEDICAL EXPENSES, INCLUDING EMERGENCY EVACUATION, SHOULD THEIR CHILD SUSTAIN A NON-ACCIDENT RELATED ILLNESS AT LAB SCHOOL.

_____
* REQUIRED SIGNATURE OF PARENT OR GUARDIAN

IF YOU HAVE A RELIGIOUS/PERSONAL OBJECTION

Because of religious convictions or personal objections, my child or ward is to receive NO BLOOD OR BLOOD PRODUCTS (please circle if applicable) or NO MEDICATION in any form (please circle if applicable). I do understand that in the event of life-death situation my child or ward, regardless of religious or personal convictions, will be administered life-sustaining first aid and medical care.

_____ _____
Signature of Parent or Legal Guardian if Applicable Date

Please sign here ONLY if you have a RELIGIOUS or PERSONAL objection.