

OUTDOOR EDUCATION RESIDENT PROGRAM
6TH GRADE STUDENT FORM

THIS FORM MUST ACCOMPANY ALL MEDICATIONS

PARENTS: Please return this form to school clinic with medications to be sent to Outdoor Education at least (1) week prior to departure unless other arrangements are made with the school Health Aide or Nurse.

INSTRUCTIONS: **Please Note**-All medications including vitamins and cough drops must be in their original containers and must be turned in to the clinic, they will be transported by the staff to the Nurse at Outdoor Education to ensure proper storage and dispensing. Please **DO NOT** pack medications in your child's bags or backpacks.-Thank you!

STUDENT'S NAME: _____ SCHOOL: _____
(Last) (First) (M.I.)

OUTDOOR EDUCATION SITE: (check one) High Peak Camp _____ YMCA _____ DATES _____

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR EACH MEDICATION YOU ARE SENDING WITH YOUR CHILD TO OUTDOOR EDUCATION. *Please print or type.*

COUNT:

MEDICATION #1: Name of medication: _____
To be given as needed _____ -OR- Number of times per day: _____
What time of day: _____ Dosage each time: _____
Reason for giving: _____ REC. _____
Special Instructions: _____ RET. _____

MEDICATION #2: Name of medication: _____
To be given as needed _____ -OR- Number of times per day: _____
What time of day: _____ Dosage each time: _____
Reason for giving: _____ REC. _____
Special Instructions: _____ RET. _____

MEDICATION #3: Name of medication: _____
To be given as needed _____ -OR- Number of times per day: _____
What time of day: _____ Dosage each time: _____
Reason for giving: _____ REC. _____
Special Instructions: _____ RET. _____

MEDICATION #4: Name of medication: _____
To be given as needed _____ -OR- Number of times per day: _____
What time of day: _____ Dosage each time: _____
Reason for giving: _____ REC. _____
Special Instructions: _____ RET. _____

(If additional space is needed, please use back of this form.)

CHECK HERE **IF ANY MEDICATIONS NEED TO BE GIVEN AT NOON ON THE DAY OF DEPARTURE.**
I hereby request and give my permission to the Outdoor Education School Nurse or designated staff to administer medication to the student identified above. I understand it is my responsibility to provide the medication(s) in the original container. **Medications that are not provided in the original pharmacy labeled containers can not be given.**

SIGNATURE _____ Date _____
Parent of Legal Guardian

SIGNATURE OF PHYSICIAN _____ Date _____
Required if not on file at school for above medication(s)