Northwest Outdoor Science School

Permission Form and Student Health History

Confidential, for NOSS Nurse and Site Supervisor use only. To be archived and destroyed by NOSS

Student's Name: ____________________________ **Student's School ID #:** ________________________

School: ________________________________ **Teacher's Name:** ___________________________________

Student is planning on attending ☐ Yes ☐ No If no, why (optional): ___________________________

X ____ **Date** _____________________________

Required Signature Parent or Legal Guardian

(If student is not attending Outdoor School, you do not need to complete the rest of this form)

CONTACT INFORMATION

Primary Contact (Legal Guardian) Name: ________________________ Relationship________________

Primary Phone # _____________________________ Secondary Phone#____________________________

Secondary Contact (Legal Guardian) Name: ________________________ Relationship________________

Primary Phone # ____________________________ Secondary Phone# ______________________________

Emergency contact (in case neither guardian listed can be reached) ____________________________

Phone: ___________________________________ Relationship: _____________________________________

Name of Student's Physician: _______________________________ Phone:____________________________

HEALTH & MEDICAL INFORMATION

Birth Date: ___________________________ Age ______ Gender (circle one): M F X

Is your student vaccinated, against COVID-19? ☐ Yes ☐ No

If yes, please list the Manufacturer ________________ and dates of the doses ________ ________ ________

Do you give NOSS consent to test your student for COVID if they show symptoms ☐ Yes ☐ No

(*If no, you consent to picking up your student ASAP*)

Specify any activities that are not allowed, or any prosthetics or other aid that will be sent.

____

Does your student have social/emotional needs? ☐ Yes ☐ No If yes please describe: __________________

____

Does your student have an IEP/504? ☐ Yes ☐ No

If yes, what is it for: ____

Does your student have asthma? ☐ Yes ☐ No If yes, should inhaler stay with student at all times? ☐ Yes ☐ No

Explain frequency/severity/treatment of attacks? ____

Known Allergies: ☐ Foods (list) _________________________________ ☐ Hay Fever ☐ Bee Sting ☐ Latex

☐ Drug Allergy (list) _____________________________ ☐ other (list)_____________________________

Clearly describe what type of exposure causes a reaction (air borne/topical/ingestion), the type of reaction possible, and treatment given: ____

Is this allergy life threating? ☐ Yes ☐ No Do they carry an EPI pen? ☐ Yes ☐ No

Special dietary needs (examples: vegetarian, vegan, gluten free, Halal, Kosher) etc.: ______________________

Health Needs (Please check all that apply)

	Bowel/ Bladder Condition		Seizure Condition
	Bedwetting		Skin Condition
	Diabetes		Sleepwalking
	Hearing Condition		Vision Condition
	Heart Condition		Other Chronic or recent illness or surgical procedures
	Mobility Issues	(specify):	
	Physical Injuries (recent)		

RECORD OF MEDICATION ADMINISTRATED BY THE OUTDOOR SCHOOL NURSE

THIS PAGE FOR OUTDOOR SCHOOL NURSE USE ONLY

STUDENT'S NAME ________________________________

SCHOOL ________________________________

DATES ATTENDING ________________________________

Initials	Signature	Initials	Signature

Use the following key for days medication not given: X = Not at site 0 = Student refuses/parent notified

Please use one line only per dose administered

Prescription Medications								
Count In/ # Initial	Count Out/ # Initial	Medication Name and Dose	Hour	Mon.	Tue.	Wed.	Thurs.	Fri.

AS- Needed Over the Counter Medications/ Treatment Record			
Date	Time	Medication, route, dosage, reason	Initials

STUDENT'S NAME: ______________________________

INSTRUCTIONS FOR MEDICATIONS, VITAMINS, SUPPLEMENTS & HERBAL REMEDIES

All medications must be turned in to the classroom teacher before departure. **Do not** pack medications in your student's luggage.

Prescription and over-the-counter medications must be in the **original container** and placed in a Ziploc bag with name on the outside. Please do not mix medications. Each type of medication should be packaged separately. Your pharmacist will provide small, labeled containers if requested. The pharmacist's label constitutes the physician's order to dispense the medication.

Non-prescription over-the-counter medications sent from home **must be in the original labeled container** and must be accompanied by **written instructions** from parent. Please only send the amount needed for the time your student is at Outdoor School

All vitamins/supplements require a note from your health care provider in order to give, see OAR 581-021-0037 (https://goo.gl/ovHkBg). 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.)

The Outdoor School Medical Staff will dispense all medications.

All medications and containers will be returned to the classroom teacher at the end of the week.

WE WILL NOT DISPENSE MEDICATIONS THAT DO NOT MEET THE ABOVE REQUIREMENTS!

MEDICATIONS - Student will bring these medications to ODS.

Name of Medication and Dosage	Time of Day	Purpose of Medication & Special Instructions

To facilitate the ODS schedule, can medication delivery times be adjusted by up to an hour? ☐ Yes ☐ No

OVER – THE – COUNTER MEDICATIONS

The Outdoor School consulting physician has issued orders permitting the dispensing of common over-the-counter medications. These medications will be dispensed, as needed, to the student in accordance with the physician's standing orders.

NOTE: Brand names have been listed but their generic equivalent (the same medication of a different brand) may be substituted.

Epinephrine, oxygen, Albuterol and instant glucose are available in the event of a life-threatening emergency in accordance with the Outdoor School physician's standing orders.

DO NOT SEND THE FOLLOWING MEDICATIONS AS THEY ARE SUPPLIED ON SITE:

Non-aspirin pain reliever (Acetaminophen, Ibuprofen, Midol)	Benzocaine (Insect Sting Swabs)	Hydrocortisone Cream 1%
Antacids (Tums)	Carmex (Chapped lips)	Imodium (Diarrhea)
Antihistamine/Decongestant (Benadryl)	Cough Syrup (Guaifenesin)	Skin Lotion (Calamine)
Antiseptic Cleanser (Hibiclens)	Cough Drops	Throat Lozenges (Chloraseptic/Cepacol)
Antibiotic Ointment (Polysporin)	Gatorade/Pedialyte	Vaseline

List any medications you DO NOT want your student to take:

STUDENT'S NAME: ______________________________

REQUIRED SIGNATURE - EMERGENCY CARE

I understand that if my student requires medical attention in addition to the specifically requested administration of medication, the Outdoor School staff will attempt to contact me first. If I am unavailable, my student's physician will be called. Should I or the student's physician be unavailable, I authorize any physician of the Northwest Regional ESD's choosing to attend to my student. I hereby authorize such physician to perform any emergency medical treatment that is deemed necessary and agree to hold harmless the Northwest Regional ESD and their offices and employees for accidents, and injuries that take place on site. I also give my permission for Outdoor School to arrange an emergency transportation if medical care is needed, and understand that any charges associated with medical care will be billed directly to me or medical insurance that I carry.

X____ Date ______________________________

Signature of Parent or Legal Guardian – REQUIRED for your student to attend

PERMISSION FOR ADMINISTRATION OF MEDICATION

I hereby give permission for the Outdoor School nurse to administer medication to the student identified above. I understand that it is my responsibility to provide such medication(s), and that all medication must be provided in the original pharmacy labeled containers. I understand that my student shall be responsible for going to the health supervisor at the specified time(s) for medications. I acknowledge that the administration of medication by Outdoor School personnel is an accommodation to be performed solely upon my request. I release and waive any and all claims, which I now have or may hereafter have against the Northwest Regional ESD and their officers and employees arising out of the administration of or failure to administer the medication to the above student or any adverse reaction to such medication.

X____ Date ______________________________

Signature of Parent or Legal Guardian

RELIGIOUS OR PERSONAL OBJECTION

If you have a religious/personal objection to medical treatment please check the appropriate boxes:

☐ **NO BLOOD or BLOOD PRODUCTS** ☐ **NO MEDICATION** in any form.

I understand and consent that in the event of a life-threatening situation, my student or ward, regardless of religious or personal convictions, will be administered life-sustaining first aid and medical care.

X____ Date ______________________________

Signature of Parent or Legal Guardian

PERMISSION TO PHOTOGRAGH

Northwest Outdoor Science School sometimes use student's photographs for publicity and public relations purposes. Photos, recordings and audio interviews could be used in a variety of ways, including NWRESD's websites, promotional and educational flyers and fact sheets, news releases, promotional and educational videos, social media channels and other promotional and educational projects.

If you do not want your student's image used for the above purposes, please check this box ☐

IF YOUR STUDENT'S MEDICAL CONDITION OR MEDICATIONS CHANGE AFTER COMPLETING THIS FORM, PLEASE SEND A SIGNED NOTE TO THE OUTDOOR SCHOOL OFFICE