Northwest Outdoor Science School

Student Leader Permission Form and 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: _____ **Outdoor School Site Assigned** _____

Is Student Leader over the age of 18? ☐ Yes ☐ No

X_____ **Date** _____

Required Signature Parent or Legal Guardian
(If student is 18 or older, they can sign for themselves)

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 student leader 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.
_____
Is your student currently receiving mental health services? _____ If yes who is the Provider? Name _____
Phone Number _____ May we contact them in a mental health emergency? _____
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 LEADER NAME _____

SCHOOL _____**DATES ATTENDING**_____

CAMP 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 LEADER NAME: _____

INSTRUCTIONS FOR MEDICATIONS, VITAMINS, SUPPLEMENTS & HERBAL REMEDIES

1. All medications must be turned in to the site nurse on arrival. **Do not** pack medications in your student leader's luggage.
2. 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.
3. 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/bring the amount needed for the time your student leader is at Outdoor School
4. 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.)
5. The Outdoor School Medical Staff will dispense all medications.
6. All medications and containers will be returned to the student leader 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 LEADER'S NAME: _____

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

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 the student's physician or I 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. I also give my permission for Outdoor School to arrange an emergency transportation if medical care is needed, and agree to hold harmless the Northwest Regional ESD and their offices and employees for accidents, and injuries that take place on site.

X_____ **Date** _____

Signature of Parent or Legal Guardian

How do we re-word this section?

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 leader, 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. I hereby grant permission to the Northwest Regional ESD to reproduce my students' likeness photographically or electronically and use such reproductions without limitation, compensation, or reservations. If you do not want your student's image used for the above purposes, please check this box ☐.

X_____ **Date** _____

Signature of Parent or Legal Guardian

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