CHEWONKI
SEMESTER SCHOOL

HEALTH INFORMATION CHECKLIST

Required Information:

_____Completed HEALTH HISTORY FORM (Note: Needs to be signed by legal guardian and student.)

_____ Completed HEALTH INSURANCE FORM

_____ Completed PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

_____ Completed green PHYSICAL EXAMINATION FORM (Note: Physical exam needs to be within a year from the start of the semester and signed by a licensed health care provider.

Additional Health Information that you may or may not need to submit:

_____ ALLERGY FORM- Must be completed for student who has allergies of any type.

_____MEDICATION FORM- Must be completed for student who will take any medications while attending Chewonki. Medications include prescriptions, over-the-counter medications, herbal remedies, and any medication students will bring to Chewonki.

_____ MENTAL HEALTH FORM- Must be completed for student who has a past or current history of mental health issues.

_____ ORTHOPEDIC FORM- Must be completed for student with a history of or ongoing orthopedic injury or condition of any type.

_____Completed purple PSYCHOTROPIC MEDICATION POLICY (Note: Needs to be signed by **legal guardian and prescriber**.)

_____USE OF SELF-ADMINISTERED EMERGENCY MEDICATIONS purple permission form needs to be signed by **legal guardian and licensed health care provider** if student is going to carry emergency medications while at Chewonki.

Health Center **Phone**: 207.882.7323 x117 or x142
Health Center **Fax**: 207.882.9564

CHEWONKI
SEMESTER SCHOOL

HEALTH HISTORY FORM

This form to be filled out by a PARENT OR GUARDIAN. Please answer ALL questions

Student Preferred Name_____

Student Full Name_____ Birth Date_____ Gender_____ Age_____
(last) (first) (m.i.)

Legal Guardian (1)_____ Phone 1: (_____)_____
Email Address_____ Phone 2: (_____)_____
Home Address _____
Business Address_____ Phone (_____)_____

Legal Guardian (2)_____ Phone 1: (_____)_____
Email Address_____ Phone 2: (_____)_____
Home Address _____
Business Address_____ Phone (_____)_____

If parent/guardians are not available in an emergency, notify:

Name_____ Phone 1: (_____)_____
Relationship_____ Phone 2: (_____)_____
Address_____

Name of family physician _____ Phone_____
Name of dentist/orthodontist _____ Phone_____
Name of therapist/counselor: _____ Phone_____

IMPORTANT ~ THE FOLLOWING MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. I hereby give permission to the medical personnel selected to order X-rays, routine tests, and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Health Center staff to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

It is my intention that the school be treated as acting *in loco parentis* for my child. Further, it is my intention that the appropriate representatives of the school be treated as 'personal representatives' for the purposes of disclosing information pursuant to the privacy regulations of the HIPPA Act. I hereby agree to the disclosure of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the school representatives related to the person's ability to participate in the school activities; and (ii) to provide relevant information to school representatives to keep me informed of my child's health status.

This form may be photocopied for use on school excursions.

Signature of Legal Guardian:_____ Date _____

I also understand and agree to abide with the restrictions placed on my activities.

Signature of Student:_____ Date _____

**RETURN BY JUNE 1ST **

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CHEWONKI
SEMESTER SCHOOL

HEALTH HISTORY FORM

This form to be completed by a PARENT OR GUARDIAN. Please answer ALL questions.

Student Name_____ Birth Date_____
(last) (first)

GENERAL HEALTH: Please read each item carefully and check each item (YES or NO) regarding any past or current medical issues or concerns.

YES-NO

- ❑ ❑ Academic Issues
- ❑ ❑ Asthma *If YES describe triggers below
- ❑ ❑ Bleeding/Clotting Disorders
- ❑ ❑ Cancer
- ❑ ❑ Chicken Pox
- ❑ ❑ Circulatory Problems
- ❑ ❑ Contact Lenses
- ❑ ❑ Diabetes *CALL IF YES
- ❑ ❑ Dizziness/Fainting
- ❑ ❑ Ear, Eye, Nose & Throat infections/issues/problems
- ❑ ❑ Eating Disorder (anorexia, bulimia, etc.)
- ❑ ❑ Epilepsy or Other Seizure Disorder *CALL IF YES
- ❑ ❑ Gastrointestinal Tract, Ulcers
- ❑ ❑ Head Injuries, Concussions, Headaches
- ❑ ❑ Heart Defect/Disease

YES-NO

- ❑ ❑ Hormone or Thyroid
- ❑ ❑ Hospitalizations or Surgeries
- ❑ ❑ Hypertension, High Blood Pressure
- ❑ ❑ Menstrual Cramps, Irregular Menstruation
- ❑ ❑ Neurological Problems
- ❑ ❑ Nutritional Modifications
- ❑ ❑ Orthodontic Treatment
- ❑ ❑ Reproductive Tract
- ❑ ❑ Skin Problems
- ❑ ❑ Sleepwalking
- ❑ ❑ Urinary Tract
- ❑ ❑ Vision
- ❑ ❑ Other (explain)

Explanations- Please provide an explanation for any "YES" answers above, attach additional information as necessary. Call the Chewonki Health Center (207) 882-7323, for any item marked *CALL IF YES _____

CHEWONKI
SEMESTER SCHOOL

HEALTH HISTORY FORM

This form to be completed by a PARENT OR GUARDIAN. Please answer ALL questions.

Student Name_____ Birth Date_____
(last) (first)

***Please select 'YES' or 'NO' for each item:**

	YES	NO
ALLERGIES Food, medications, bee/insect stings, pollen and any other known allergies. A 'No' response means 'No Known Allergies' **If 'Yes' please complete the ALLERGIES Form**	☐	☐
MEDICATIONS Prescription medications, over-the-counter medications, dietary supplements (multivitamins), herbal remedies, and any other medications. **If 'Yes' please complete the MEDICATIONS Form**	☐	☐
MENTAL HEALTH CONDITIONS ADD/ADHD, anxiety, depression, past history of suicide attempt or ideation, substance addiction/abuse, eating disorder, self harm, family issues, or any other mental health issues. **If 'Yes' please complete the MENTAL HEALTH Form**	☐	☐
ORTHOPEDIC CONDITIONS OR INJURIES Shoulder, arm, elbow, hand, neck, back, hips, legs, knee, ankle, foot, recurrent strains of muscles, recurrent sprains of joints, hernia, other musculoskeletal issues, and other athletic or orthopedic injuries. **If 'Yes' please complete the ORTHOPEDIC Form**	☐	☐

CHEWONKI
SEMESTER SCHOOL

PHYSICAL EXAMINATION FORM

TO THE LISCENED HEALTH CARE PROVIDER:

In order for you to properly assess the medical appropriateness of this student's participation in Chewonki, we offer the following information for you about the program. Please note that we have a very small faculty and staff, and it is difficult for us to care for students with special requirements. Our goal is to make certain that we can provide the level of professional care necessary for the student to benefit from the Chewonki experience. We appreciate your honesty as you fill out the form. Please call our Health Center, if you have any questions at all.

Below are some examples of the rigorous activities in which a student will be expected to participate:

Physical components: 5 day hiking/boating trip, daily outdoor physical activity, 2 nights solo camping, weekly science fieldtrips, chopping wood, cleaning campus buildings, working on a farm, operating cabin woodstoves.

Social components: Chewonki is a boarding school environment. Students will share wood-heated cabins with 5-7 other students, and eat family-style in a dining hall setting (food allergies can be accommodated, but must be indicated on the enclosed health forms).

Academic components: Full weekday class schedule, 2-4 hours of homework a night.

General Medication Information
We administer medications at meals times and before bedtime. Outside of these times students are usually away from the Health Center and often engaging in outside learning. Prescribed medications will be self-administered by students while on their 2-day solo experience. Students are permitted to self-administer multi-vitamins, rescue medications, ointments, and birth control medications throughout the semester with signed permission.

Psychotropic Medications
Chewonki has a psychotropic medication policy, which requires a student to be stable on a medication for one month prior to attending our programs. Please carefully review and sign the policy for any student prescribed psychotropic medications.

The program is a lot of fun, the teachers are warm and caring, the atmosphere is relaxing, exciting, and rigorous. At the same time, we ask for a tremendous commitment of energy to every aspect of the Chewonki experience, and it is very challenging, physically, emotionally, and academically. Thank you for taking the time to complete this form so we can best support your student.

Dawn Dill, RN
Chewonki Foundation
485 Chewonki Neck Road
Wiscasset, ME 04578
ddill@chewonki.org

CHEWONKI
SEMESTER SCHOOL

PHYSICAL EXAMINATION FORM

This sheet needs to be completed by a LICENSED HEALTHCARE PROVIDER. Please answer ALL questions.

STUDENT NAME: _____ **DOB:** _____

IMMUNIZATION HISTORY:

Chewonki requires all immunizations to be up to date. We recommend every student have a current TB Mantoux test within one year of their arrival to Chewonki. Tetanus immunizations are required to be within ten years. Please give all dates (Month /Year) of immunization for:

HepB					
DTap					
Tdap					
IPV					
Pneumococcal Vaccine					
Influenza Vaccine					
MMR					
Varicella					
HepA					
HPV					
MCV					
BCG					

Tuberculin test (most recent) & results _____

HEALTH EXAMINATION BY LICENSED HEALTHCARE PROVIDER:

Date of Examination_____ Height_____ Weight_____ Temperature_____

The student is under the care of a healthcare provider for the following condition(s): _____

_____

Treatment to be continued during participation in program_____

Is student currently taking prescribed medications? **Yes** ❑ **No** ❑

Is student currently taking any psychotropic medications? **Yes** ❑ **No** ❑

*If yes please read and sign **Psychotropic Medication Policy**

Does student have permission to self administer prescribed medications on 2-day solo experience? **Yes** ❑ **No** ❑

Medication(s)_____

Dosage and Frequency _____

Restrictions or limitations_____

Any medically prescribed meal plan or dietary restrictions_____

Known allergies (*food, drugs, plants, insects, etc.)*_____

Additional information for school health care staff_____

IN MY OPINION, THIS STUDENT IS❑ / IS NOT❑ ABLE TO PARTICIPATE IN A *PHYSICALLY ACTIVE* AND *CHALLENGING* PROGRAM.

By my signature, I attest that the information in this form is correct and the student named above is medically cleared to participate in Chewonki, based on the information provided on page one of this form along with the background information from the student and my physical examination of him/her. I have examined the student named above within a year previous to the start of the program.

Licensed Healthcare Provider_____ Phone_____

Address_____

Signature _____ Date _____

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Health Center **Fax**: 207.882.9564

CHEWONKI
SEMESTER SCHOOL

HEALTH INSURANCE FORM

This form to be completed and submitted with the Health History Form. Please answer ALL questions. If you do not carry health insurance please read and sign the statement below.

Student Name_____ Birth Date_____
(last) (first)

Policy Holder's Name_____ Policy Number_____
Policy Holder's Birth Date_____ Group Number_____
SSN or Insurance ID_____ Rx Bin Number_____
Policy Holder's Relationship_____

Insurance Carrier_____ Carrier Phone #_____
Claims Processing Address_____

Prescription Plan Carrier_____ Prescription Plan #_____

If you do not carry health insurance read and sign the statement below.

By signing below I am indicating that I will assume responsibility for any and all medical expenses that may be incurred during my child's participation in a program at Chewonki Foundation.

I acknowledge that one of the requirements for participation in programs sponsored by the Chewonki Foundation involves carrying health insurance. I am requesting that the Chewonki Foundation in this situation make an exception, because I am unable to provide such coverage for my child during my child's intended time of participation.

Should my child become injured or ill, I accept any judgments made by Chewonki Health Center staff regarding the health care needs of my child. The Chewonki Foundation's Health Center staff will make every effort to contact me and keep me apprised in any and all situations that require my child to be seen by a doctor. Yet I also accept that the Health Center staff will make recommendations without regard to any costs I may incur as a result of not providing insurance. I also agree to reimburse The Chewonki Foundation for any and all such costs that the Chewonki Foundation may incur in an effort to expedite care for my child.

Signature of parent or guardian:_____ Date:_____

Printed name of parent or guardian:_____

Health Center **Phone**: 207.882.7323 x117 or x142
Health Center **Fax**: 207.882.9564

CHEWONKI
SEMESTER SCHOOL

Permission to Administer Over-the-Counter Medications

This form to be completed by a PARENT OR GUARDIAN.

Student Name_____ Birth Date_____
(last) (first)

Important Please Read: The medications listed below will be administered per Chewonki protocol and standing orders. If you do not want your child to receive any of the listed medications, please indicate by drawing a line through the medication with parent's initials next to the medication.

List any additional Over-the-Counter Medications (OTC), Vitamins & Supplements that your child will be bringing to Chewonki. A written order from the doctor is needed for any OTC medications (including vitamins) while at Chewonki. If you would like your child to take additional over the counter medications during their time at Chewonki, we will secure the supply and distribute as directed. Students are allowed to self administer multi-vitamins, rescue medications, ointments, and birth control medications while at Chewonki with signed permission.

All medications will be collected by the Health Center on opening day.

1. Acetaminophen
2. Bactroban ointment
3. Dextromethorphan or Guaifenesin
4. Diphenhydramine tablets or topical
5. Hydrocortisone 1% ointment / lotion
6. Ibuprofen
7. Kaopectate
8. Loperamide
9. Loratadine or Zyrtec
10. Meclizine or dimenhydrinate
11. Milk of Magnesia, Senecot, or other similar product to treat constipation
12. Mylanta
13. Naphcon eye drops
14. Nix
15. Pseudoephedrine or Phenylephrine HCL
16. Swimmer's ear drops- 1:1, alcohol:vinegar solution
17. Tolfanate cream 1%, tioconazole ointment 6.5%
18. Tums, or other antacid

Please sign below, indicating that Chewonki staff members have your permission to administer these medications to your child if he/she becomes sick and it should be necessary and they have permission to self administer on the 2-day solo experience.

Student may self administer the following multi-vitamins, birth control pills and ointments:_____

_____

_____

Signature of parent or guardian:_____ Date _____

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CHEWONKI
SEMESTER SCHOOL

ALLERGIES FORM

If applicable, this form to be completed by a PARENT OR GUARDIAN and submitted with the Health History. Please answer ALL questions

Student Name_____ Birth Date_____
(last) (first)

On the health history form, you listed that the student has allergies. Chewonki collects detailed information on any student with allergies so that accommodations can be made to suit each student. Please thoroughly answer the questions below so that we have the best information to support your student. **Complete the following information for EACH allergy (copy this form as necessary).** Attach additional sheets as necessary and please call with any questions. *If your student carries epinephrine for any allergy please complete the **"Use of Self-Administered Emergency Medication"** permission form.

ALLERGY OR ALLERGEN: _____

When was student diagnosed with this allergy?_____

How was student diagnosed with this allergy?_____

When was the last allergic reaction?_____

What does their allergic reaction look like (symptoms)?_____

_____

Has the student ever had an anaphylactic reaction? ❑YES ❑NO If yes, when?_____

Has the student ever been hospitalized for this allergy? ❑YES ❑NO If yes, when?_____

Is the student on an allergy desensitization program? ❑YES ❑NO If yes, will the student need desensitization at Chewonki?_____

Additional information:_____

_____

_____

ALLERGY OR ALLERGEN: _____

When was student diagnosed with this allergy?_____

How was student diagnosed with this allergy?_____

When was the last allergic reaction?_____

What does their allergic reaction look like (symptoms)?_____

_____

Has the student ever had an anaphylactic reaction? ❑YES ❑NO If yes, when?_____

Has the student ever been hospitalized for this allergy? ❑YES ❑NO If yes, when?_____

Is the student on an allergy desensitization program? ❑YES ❑NO If yes, will the student need desensitization at Chewonki?_____

Additional information:_____

_____

_____

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CHEWONKI
SEMESTER SCHOOL

MEDICATION FORM

If applicable, this form to be completed by a PARENT OR GUARDIAN in consultation with your licensed family health care provider or prescribing physician and submitted with the Health History. Please answer ALL questions

Student Name_____ Birth Date_____
(last) (first)

All medications at Chewonki will be administered by our trained faculty and staff [with the exception of creams, ointments, multi-vitamins, birth control pills, and rescue medications (with appropriate documentation)]. The information you provide on this form will be used as a resource for Chewonki faculty and staff. **Complete the following information for EACH medication your student will bring to Chewonki (copy this form as necessary).** A prescription from a licensed health care provider is required for all medications taken at Chewonki, including over-the-counter medications or herbal supplements.

***Chewonki has a Psychotropic Medication Policy, please review and sign the policy with your licensed family health care provider or prescribing physician if the student will take psychotropic medications (including medications for ADD) while at Chewonki**.

Please note: *Chewonki provides regular over-the-counter medications for minor illness (headaches, cramps, cold and flu, sore throat, etc.), we ask that your student does not bring these medication unless they are expected to take them on a daily or regular basis.*

Medication Name:_____ Reason for taking medication:_____
Regular Dose:_____ Frequency & Time of Dose(s):_____

If this medication is to be given at student's discretion or as needed please have the prescribing physician indicate medication is PRN or "as needed".

Signs & symptoms that indicate need for medication, *if applicable*:_____
Side Effects:_____
Harmful Interactions (i.e. don't give with ibuprofen):_____
In the event of a missed dose do the following: ❑Take immediately when remembered ❑Double next scheduled dose
❑Other:_____
What happens if a student misses a dose?_____

With certain medications it is easier and safer to get refills at our local pharmacy in Maine. If appropriate the Chewonki Health Center will help to coordinate mediation refills, please call to make arrangements.

Will the student come to Chewonki with sufficient medication for the duration of the program? ❑YES ❑NO
Additional Information:

Medication Name:_____ Reason for taking medication:_____
Regular Dose:_____ Frequency & Time of Dose(s):_____

If this medication is to be given at student's discretion or as needed please have the prescribing physician indicate medication is PRN or "as needed".

Signs & symptoms that indicate need for medication, *if applicable*:_____
Side Effects:_____
Harmful Interactions (i.e. don't give with ibuprofen):_____
In the event of a missed dose do the following: ❑Take immediately when remembered ❑Double next scheduled dose
❑Other:_____
What happens if a student misses a dose?_____

With certain medications it is easier and safer to get refills at our local pharmacy in Maine. If appropriate the Chewonki Health Center will help to coordinate mediation refills, please call to make arrangements.

Will the student come to Chewonki with sufficient medication for the duration of the program? ❑YES ❑NO
Additional Information:

I hereby give my permission for my child (named above) to receive the medication(s) listed on this form and to self-administer on the two-day solo experience while enrolled at Chewonki. A licensed health care provider or physician has prescribed the above listed medications. I HEREBY RELEASE the Chewonki Foundation and Chewonki staff from any and all liability which may result from my child taking the prescribed medication(s).

Signature of parent or guardian:_____ Date _____

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CHEWONKI
SEMESTER SCHOOL

MENTAL HEALTH FORM

If applicable, this form to be completed by a PARENT OR GUARDIAN and submitted with the Health History. Note that Chewonki is not a program for students to resolve or work on behavioral, emotional, or psychological problems. Please answer ALL questions.

Student Name_____ Birth Date_____
(last) (first)

On the health history form, you noted a past or present mental health issue. With proper information we will be able to determine how to best support your student. Thank you for responding thoroughly and as soon as possible.

Indicate which of the following the student has been diagnosed with or received treatment or counseling for:

❑ ADD/ADHD ❑ Anxiety Disorder ❑ Depression ❑ Eating Disorder ❑ Family Issues/Divorce

❑ Self Harm ❑ Substance Abuse/Addiction ❑ Suicidal Ideation or Attempt

❑ Other: _____

Please give date of when the above first occurred or was diagnosed:_____

Has the student met with a counselor or therapist in the last two years?_____

Is the student currently seeing a counselor or therapist?_____

Counselor/Therapist Name:_____ Counselor/Therapist Phone:_____

Under the current treatment, how does the student's mental health issue manifest itself?_____

_____

_____

Does the mental health issue interfere with school and/or social interactions? ❑YES ❑NO If YES, please explain:_____

_____

_____

During the last two years has the student taken any medications for mental health issues? ❑YES ❑NO_____

Is student currently taking medications for mental health issues? ❑YES ❑NO If YES, please complete the MEDICATION form.

Has the student ever been hospitalized for psychiatric illness? ❑YES ❑NO If YES, please give date, for how long and reason._____

_____

For stress related issues and/or mental health issues exacerbated by stress:

What triggers stress for the student?_____

_____

_____

What coping strategies will your student use if faced with stressful situations while at Chewonki?_____

_____

_____

_____

Additional Information:_____

_____

Thank you for completing this form, we appreciate your careful attention. If you have any questions please contact us!

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CHEWONKI
SEMESTER SCHOOL

ORTHOPEDIC FORM

If applicable, this form to be completed by a PARENT OR GUARDIAN and submitted with the Health History. Please answer ALL questions

Student Name_____ Birth Date_____
(last) (first)

On the health history form, you noted a past or present mental health issue. With proper information we are able to accommodate many issues. Thank you for responding thoroughly and as soon as possible. **Complete the following information for EACH injury (copy this form as necessary).** Attach additional sheets as necessary and please call with any questions.

Injury:_____ When:_____
How was injury treated?_____
Did the student have physical therapy? ❑YES ❑NO If YES, for how long?_____
Does the student still have pain as a result of this injury? ? ❑YES ❑NO If YES, what causes the pain and for how long?____

_____

_____

Does the student still have loss of function or disability as a result of this injury? ❑YES ❑NO If YES, please describe the disability:_____

_____

Which description best describes the student's current condition: ❑*No longer a concern* ❑*Stable* ❑*Improving* ❑*Worsening*
Since this injury, has the student played sports, carried a backpack, run or hiked for regular intervals? Please explain:_____

_____

_____

Do you anticipate the student being limited in their ability to participate in a physically demanding program? ❑YES ❑NO
If YES, for which activities and for how long?_____

_____

If this injury occurred recently (within the past 6 months) or is persistent, please have your licensed health care provider or physician acknowledge that participant at Chewonki will not cause further damage or harm.

Injury:_____ When:_____
How was injury treated?_____
Did the student have physical therapy? ❑YES ❑NO If YES, for how long?_____
Does the student still have pain as a result of this injury? ? ❑YES ❑NO If YES, what causes the pain and for how long?____

_____

_____

Does the student still have loss of function or disability as a result of this injury? ❑YES ❑NO If YES, please describe the disability:_____

_____

Which description best describes the student's current condition: ❑*No longer a concern* ❑*Stable* ❑*Improving* ❑*Worsening*
Since this injury, has the student played sports, carried a backpack, run or hiked for regular intervals? Please explain:_____

_____

_____

Do you anticipate the student being limited in their ability to participate in a physically demanding program? ❑YES ❑NO
If YES, for which activities and for how long?_____

_____

If this injury occurred recently (within the past 6 months) or is persistent, please have your licensed health care provider or physician acknowledge that participant at Chewonki will not cause further damage or harm.

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CHEWONKI
SEMESTER SCHOOL

CHEWONKI PSYCHOTROPIC MEDICATION POLICY

If student will take a psychotropic medication at Cheownki review and sign this policy with the prescribing physician.

Student Name_____Birth Date_____
(last) (first)

In order to insure the safety and well being of all of our participants (campers and students) at the Chewonki Foundation, we ask that participant's legal guardians and licensed health care provider review and sign these guidelines. Our programs are rigorous and encourage children to stretch beyond what they believe to be their own boundaries. Therefore, in order to succeed, a child needs to have a level of resilience and strength while participating at Chewonki.

The Chewonki Foundation guidelines and expectations are as follows:

1.) All participants taking psychotropic medications will have a definitive diagnosis that has been established and documented by a physician or mental health professional.
2.) All participants taking psychotropic medications will be under the regular oversight and care of a physician or mental health professional who signs off on the participant's well being. Consultations, in person or by phone, are strongly encouraged to continue while at Chewonki and can be arranged with the support of the health center staff.
3.) All participants who have regular appointments with a counselor or psychiatrist prior to arriving at Chewonki, whether on a psychotropic medication or not, are strongly encouraged to continue with counseling sessions. The health center staff will provide the private space and time for such appointments.
4.) If the dose of a psychotropic medication is to be adjusted while a participant is residing at the Chewonki Foundation, the physician accepts all responsibility for the assessment and treatment of the participant's mental well-being. Chewonki health center staff are not trained, nor staffed, to assess the psychiatric needs of a participant.
5.) If at any time a participant, or any other individual involved at the Chewonki Foundation is deemed emotionally unstable by the staff or health center, and is a risk to him/herself or anyone else on campus, s/he must leave immediately and receive proper treatment. It is then the parent, or guardian's, responsibility to assume all care for the participant.
6.) In accordance with Maine state law, it is our medication policy to have all medications delivered in a pharmacy labeled container and state the following in English: student name, name of medication, strength of medication, dosage and route, time and frequency of dose. The parent is responsible for delivering this medication to the health center at the Chewonki Foundation where the medication will be administered to the student or camper by designated health care staff.

Thank you for your attention to this matter. We believe children who are healthy in mind, body and spirit are children who are ready to learn and experience the world around them.

Sincerely,

Dawn Dill, RN

Signature of all in agreement of above:

Physician: _____

Participant's Legal Guardian: _____

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CHEWONKI
SEMESTER SCHOOL

USE OF SELF-ADMINISTERED EMERGENCY MEDICATION

This form to be signed by legal guardian and licensed health care provider if student is to carry emergency medications.

As the legal guardian of _____(student's name), during his/her time at Chewonki, the above listed child is permitted to have readily available (carry or pessess outside of the regular supervision of the healthcare staff) self-administered as medically necessary: (*circle all that apply or list other emergency self-medication device.)*

1. Asthma Inhaler
2. Epinephrine
3. Other (please list):_____

I have read the State of Maine Law as listed below, and confirm that my child has the knowledge and the skills to safely have readily available and self-administer the indicated emergency medication while participating at Chewonki.

_____

Licensed Health Care Provider Signature Date

_____

Legal Guardian Signature Date

Excerpt of Maine Law on Self-Administration of Emergency Medications:
(1) A student who self-administers an asthma inhaler or an epinephrine pen must have the prior written approval of the student's primary health care provider and, if the student is a minor, the prior written approval of the student's parent or guardian.

(2) The student's parent or guardian must submit written verification to the school from the student's primary health care provider confirming that the student has the knowledge and the skills to safely possess and use an asthma inhaler or an epinephrine pen in school.

(3) The school nurse shall evaluate the student's technique to ensure proper and effective use of an asthma inhaler or an epinephrine pen in school.

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