SCHOOL PRESENTLY ATTENDING ROCKY MOUNTAIN ACADEMY OF EVERGREEN

MEDICAL INFORMATION

Height _____ Male _____ Student's Name _____

Weight _____ Female _____ Last First Middle

Birth _____ Age _____ Child Resides With (**circle**) Both Parents Father

Day / Month /Year Mother Other (specify) : _____

Complete Address _____

Number Street Apt # City Zip

Father's Name _____ Mother's Name _____

Father's Home Phone _____ Mother's Home Phone _____

Father's Work Phone _____ Mother's Work Phone _____

Father's Cell or Pager _____ Mother's Cell or Pager _____

Father's Work Hours _____ Mother's Work Hours _____

Relative or Neighbor's 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 _____

I. The following medications, provided by parent, may be administered by the RMAE Staff member in order to relieve minor pain and discomfort**.**

Please list medications that you expect to send with your child:

_____ _____

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

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, RMAE 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, the closest medical facility will be contacted. I hereby authorize these physicians to perform 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.

_____ Date _____

REQUIRED SIGNATURE OF PARENT OR LEGAL GUARDIAN

Student's Name

_____

Last First

II. Please list any medical condition/concern, recent injury or hospitalization: _____

_____

Specify any activities that are not allowed, or any prosthetic or other aid that will be sent: _____

_____

III. Date of last tetanus shot (if known)? _____

IV. Does your child have asthma? (**Circle)** Yes No Please explain: frequency/severity/treatment of attacks :

_____

Students who need to carry inhalers should bring an extra one to be kept with RMAE staff member.

V. Known allergies (**Circle** if applicable): Hayfever Food Bee Sting Drug Allergy [name of drug] _____

Explain reaction: _____

VI. Does your child need a special diet? _____ If yes, explain: _____

You may wish to send juice from home if your child is allergic to milk, or furnish food substitutes if your child requires a special diet.

VII. **Circle** any condition which warrants a bottom bunk: Bedwetting Frequent urination Sleepwalking Seizures

Restlessness Other Further explanation: _____

VIII. 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.

_____

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 applicicable). 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.

_____ Date _____

Signature of Parent or Legal Guardian if Applicable

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

OVERNIGHT MEDICATION PERMISSION FORM

THIS FORM MUST ACCOMPANY ALL MEDICATIONS

NOTE TO CLINIC AIDE: This form is to be given to all students mid-week prior to coming on this trip. This form MUST accompany all medications brought to school the day ***before*** departure. NOTE TO PARENTS: If your child has medication, please complete this form and return it with the medication, in the original pharmaceutical container, first thing in the morning on the day of departure. Label each container with your child's name.

INSTRUCTIONS:

1. All students taking medication of any kind, including such medications as vitamins and cough drops, **must** turn them in to the school clinic before leaving. ***Please do not pack medications in your child's bag***.
2. Please **do not** mix medicine. Use one container for **each** medicine.
3. Prescriptions or over-the-counter medications **must** be in their **original** containers.

Student's Name _____ Name of _____

Last First Middle

Please provide the following information for each medication which you are sending on this trip.
PLEASE PRINT OR TYPE:

MEDICATION #1 _____

CIRCLE ONE: As needed Daily What time is daily medication taken at _____

NUMBER OF TIMES PER _____ DOSAGE EACH _____

REASON FOR GIVING _____

SPECIAL _____

MEDICATION #2 _____

CIRCLE ONE: As needed Daily What time is daily medication taken at _____

NUMBER OF TIMES PER _____ DOSAGE EACH TIME _____

REASON FOR GIVING _____

SPECIAL _____

MEDICATION #3 _____

CIRCLE ONE: As needed Daily What time is daily medication taken at _____

NUMBER OF TIMES PER _____ DOSAGE EACH TIME _____

REASON FOR GIVING _____

SPECIAL _____

DOES ANY MEDICATION NEED TO BE GIVEN AT NOON ON THE FIRST **Circle YES or NO**

If student has more medication than provided for in the above space, please list them with the required information on another attached sheet.

Also list any recent injuries or illnesses that have occurred since completion of the Medical Information form for the trip.

PERMISSION FOR ADMINISTRATION OF MEDICATION

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 this medication(s). 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 that 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.

_____ Date _____

REQUIRED SIGNATURE OF PARENT OR LEGAL GUARDIAN