SAN MATEO OUTDOOR EDUCATION:

STUDENT HEALTH INFORMATION

Dear Parent,

To help us provide a safe and enjoyable experience for your child, we need to know about your child's current health status and any medications that he/she is taking. Please take a moment to fill in the below questionnaire to see if the medication form (see back) needs to be completed.

Please let us know who we should contact if we have any medical questions regarding your child.

If your child is under a doctor's care for an acute or chronic problem including food allergies or dietary restrictions, your physician needs to know that the child will be away from home for **four or five** full days.

Any medication brought to camp must be in its original prescription or manufacturer's container.

STUDENT INFORMATION:

Print name of student	☐M ☐F Sex	Birth date	School

EMERGENCY CONTACT:

Print name of guardian	Relationship	Contact phone number

MEDICAL CONDITION:

Does your child have a life threatening allergy? ☐ Y ☐ N

Does your child have diabetes? ☐ Y ☐ N

Does your child have a serious medical condition that may require special attention? ☐ Y ☐ N

If you answered yes to any of the above, please call (650) 747-0414.

MEDICATIONS:

Will your child be bringing any prescription medication to camp? ☐ Y ☐ N

Will your child be bringing any over-the-counter medication to camp? ☐ Y ☐ N

Will your child be bringing any vitamins to camp? ☐ Y ☐ N

Will your child be bringing any herbal remedies to camp? ☐ Y ☐ N

Does your child have an EpiPen? ☐ Y ☐ N

Does your child use an inhaler? ☐ Y ☐ N

Does your child have any type of nasal spray? ☐ Y ☐ N

If you answered yes to any of the above, please complete the back of this form.

OTHER MEDICAL CONCERNS:

Please note any other medical concerns that you believe we should be aware of.

SAN MATEO OUTDOOR EDUCATION:

MEDICATION FORM

TO BE COMPLETED BY PARENT:

A **doctor's signature** is required for **all prescription** and **non-prescription** medication to be administered to your child. Please refer to the list of non-prescription medication available at Outdoor Education on the medical information and permission form before sending non-prescription medication from home.

Print name of student	☐M ☐F Sex	Birth date	School

I request and authorize my child (named above) to be assisted by a designated person in taking their medication (described below) at the Outdoor Education Program, in compliance with the program's policies and procedures.

Signature of custodial parent or guardian	Date signed (month, day, year)	Phone Number

TO BE COMPLETED BY PHYSICIAN:

PHYSICIAN'S INSTRUCTIONS FOR ACUTE OR CHRONIC PROBLEM

If the child is under your care for an acute or chronic problem including food allergies or dietary restrictions, please give instructions in this space for care of the child.

	1. Name of medication	2. Name of medication	3. Name of medication
Purpose of medication:			
Dosage prescribed:			
Time schedule:			
Dose form: (liquid, tablet, etc.)			
Date of prescription:			
Length of time medication is necessary:			

	4. Name of medication	5. Name of medication	6. Name of medication
Purpose of medication:			
Dosage prescribed:			
Time schedule:			
Dose form: (liquid, tablet, etc.)			
Date of prescription:			
Length of time medication is necessary:			

Precautions, special instructions, possible adverse effects, or comments: _____

The above-named child, for whom the above medication is prescribed, is under my care.

Print Name of Physician	CA License Number

Address (street number, street name, suite or room number, city, and zip code)	Telephone number

Signature of physician	Date signed (mo./day/yr.)