McDowell Farm School

105 Delong Rd Nauvoo, AL 35578
mcdowellfarmschool.com
Phone: 205.387.1806
Fax: 205.221.3454

School _____

STUDENT HEALTH FORM (All information is confidential-PLEASE PRINT)

STUDENT NAME_____
(LAST) (FIRST) (MIDDLE) (PREFERRED NAME)

STUDENT INFORMATION: Date of Birth: _____ Sex: M / F Age _____ Grade: _____ Height & Weight: _____

Primary Physician _____ Physician Phone _____

CONTACT INFORMATION:

Parent / Guardian Name _____

Address_____
(STREET) (CITY) (STATE) (ZIP CODE)

Phone_____

INCLUDE AREA CODE Primary Number (ex. Home) Secondary Phone Number (ex. Cell) Alternate Phone Number (ex. Work)

Parent email address _____

In case of an EMERGENCY, CONTACT: _____
(NAME & Relationship to Student) (Day Phone) (Evening Phone)

Is student on a special diet? Y / N Please explain, (what they CAN eat as well as what they CANNOT eat): _____

_____

**** If special foods must be sent to camp with your child, please contact the Program Coordinator at 205.387.1806 ****

ALLERGY INFORMATION **(USE ADDITIONAL SHEETS IF NECESSARY)**

To the best of your knowledge does your child have any allergies? **YES / NO** (Circle correct response)
If **YES** was circled **please indicate to which of the following your child is allergic. Please be specific:**

FOODS: _____

PLANTS: _____

MEDICINE ALLERGIES: _____

ANIMALS: _____

OTHER: _____

INSECTS: _____

Please indicate what treatment your child should receive if exposure occurs to any of the first five (Any medications to which your Child is allergic will NOT be given): _____

_____

**** If your child is bringing an EPIPen to McDowell you MUST talk with our Program RN before your child arrives.****
CONTACT PROGRAM RN - BETHANYNURSE@CAMPMCDOWELL.COM OR 205.387.1806 EXT 119

PLEASE READ, COMPLETE AND SIGN THE BACK SIDE **[pg. 2]** OF THIS FORM

REGARDING MEDICATIONS WHILE AT MCDOWELL FARM SCHOOL

GENERAL RULES: **All medications **must** be in their original container with the student's name and school written on the container.
There **must be clear directions on when &/or why to give the medication.
NOTE: Give as directed is NOT acceptable
The container **must specify the strength and dose of the medication.
If it is an Over-The-Counter medication **it MUST be age-appropriate *and* will be given following manufacturer recommendations. If it is not recommended for your child's age and your child's Health care provider prescribed it then a note from that provider must be sent with the OTC medication.

PRESCRIPTION MEDICATIONS:

The following section must be filled out by the student's PARENT or LEGAL GUARDIAN.
(ALL MEDICATION IS DISPENSED BY A LICENSED NURSE OR AUTHORIZED SCHOOL PERSONNEL.)

List **ALL PRESCRIPTION MEDICATIONS** you will send with your child and circle the best time(s) to administer this medicine to the child, choosing from the following:
B*= Before Breakfast, **B**= After Breakfast, **L**= After Lunch, **C**=Canteen (4PM), **D**= After Dinner, **HS**= At Bedtime
(Attach Additional Sheet if Necessary) **(PLEASE CIRCLE)**

Medication_____ Dosage_____ Reason_____ Time Given- **B* B L C D HS**
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OVER THE COUNTER (OTC) MEDICATIONS:

**** ALL OTC MEDICATIONS MUST BE PROVIDED BY PARENTS/LEGAL GUARDIANS OF THE STUDENT ****
Please list the OTC medicines that you will be sending with your child on the lines provided below:

Name of OTC Medication	**Reason(s) for Giving**
(EXAMPLE) CLARITIN	(EXAMPLE) SEASONAL ALLERGIES– EVERY DAY BEFORE BREAKFAST
_____	_____
_____	_____

In the event of unexpected illnesses, limited OTC medicines will be available for your child–
Which of the following medicines do you permit to be given to your child by our Nurse?

Ibuprofen: Yes__ No__ **Acetaminophen:** Yes__ No__ **Benadryl:** Yes__ No__ **Cough Drops:** Yes__ No__ **Tums:** Yes__ No__

PHOTO RELEASE *"I give my permission for any photos or videos taken of my child or any artwork and writing made by my child during educational programs at the Center to be used for the public relations of the program."*

ACCIDENT INSURANCE COVERAGE Accident insurance costs are covered in the program fee and protect all students throughout the program. The maximum benefits are: Sickness, $1000; Accidents, $2500; and Loss of Life, $2500. Parents or guardians are responsible for expenses in excess of these amounts.

MEDICAL AUTHORIZATION AND RELEASE
"I AUTHORIZE THE NURSE OR AUTHORIZED SCHOOL PERSONNEL, THE TASK OF ASSISTING MY CHILD IN TAKING THE ABOVE MEDICATIONS. I GIVE THE NURSE PERMISSION TO SPEAK WITH MY CHILD'S HEALTH CARE PROVIDER OR PHARMACIST AND AUTHORIZE MY CHILD'S HEALTH CARE PROVIDER OR PHARMACIST TO SPEAK WITH THE NURSE SHOULD A QUESTION COME UP ABOUT ONE OF MY CHILD'S MEDICATIONS. ALL HEALTH INFORMATION IS CONSIDERED CONFIDENTIAL AND WILL BE SHARED ONLY ON A NEED-TO-KNOW BASIS TO ENSURE THE SAFETY OF YOUR CHILD."
"This is to certify that the information provided on this form is accurate to the best of my knowledge,"

_____

SIGNATURE OF PARENT or LEGAL GUARDIAN DATE ***Copy this page***