McDowell Farm School

STUDENT HEALTH FORM

All information is confidential. **PLEASE PRINT NEATLY!**

This form must be filled out by the student's **PARENT or LEGAL GUARDIAN!**

Student name: (Last) (First) (Middle)		Date of Birth:	Sex:
Age: Grade: Height/Weight:		Preferred name (if different from above):	
Address: City: State: Zip Code:			
Parent/Guardian name: (Last) (First)		Relationship to student:	
Cell Phone:	Work Phone:	Email Address:	
Other Emergency Contact: (Last) (First)		Relationship to student/Phone Number:	
Primary Physician:		Physician Phone:	

ls student on a special diet? Y / N If so, please explain what they CAN eat as well as what they CANNOT eat:

_____

_____

****If special foods must be sent with your child,
please contact the Farm School Program Coordinator at 205-387-1806, ext 105 or
farmschool@campmcdowell.com****

ALLERGY INFORMATION

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

FOODS:	
PLANTS:	
MEDICINE ALLERGIES:	
ANIMALS:	
INSECTS:	
OTHER:	

Please indicate what treatment your child should receive if exposure occurs (Any medications to which your child is allergic will NOT be given):

_____

**** If your child is bringing an EPI-PEN,
you MUST contact the Farm School Nurse at farmnurse@campmcdowell.com**

ADDITIONAL HEALTH CONCERNS: _____

_____

PLEASE READ, COMPLETE and SIGN **PAGE 2** OF THIS FORM!!

STUDENT MEDICATIONS WHILE at MCDOWELL Farm School:

- 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 Healthcare provider prescribed it then a note from that provider must be sent with the OTC medication.

PRESCRIPTION MEDICATIONS:

ALL MEDICATION IS ADMINISTERED BY A LICENSED NURSE, EMT OR AUTHORIZED SCHOOL PERSONNEL. Add additional sheet, if necessary.

List all prescription medications that you will send with your child. Circle the 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
*If a time is not selected, medicines will be given after breakfast.

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.
Circle "As Needed Only", if medication is not taken daily.

Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
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In the event of unexpected illnesses, our Nurse/EMT will have limited OTC medicines available for your child–
Which of the following medicines do you permit to be given to your child by our Nurse/EMT?
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 Camp McDowell to be used for the public relations of the program." (Please note if you DO NOT give photo release permission)

MEDICAL AUTHORIZATION AND RELEASE

"I AUTHORIZE THE NURSE, AUTHORIZED SCHOOL PERSONNEL, OR AUTHORIZED CAMP STAFF 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. I ALSO UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL MEDICAL TREATMENT AND OTHER HEALTH CARE SERVICES PROVIDED TO MY 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**

VERY IMPORTANT! **<u>Medicine Reminder</u>** **PLEASE READ!**

for Parents

- Medicines at McDowell Farm School are subject to the same rules as medicines brought to school for administration by the school nurse.

- Scheduled medicine times are: Before Breakfast, After Breakfast, After Lunch, Canteen, After Dinner and at Evening Snack.

- Prescription medicines **MUST** be in their original containers and have a label containing:
    - Student Name
    - Name of Prescription Drug
    - Strength of Prescription Drug
    - Administration directions ("give as directed" is **NOT** acceptable)
    - Parents must indicate what time medication is to be taken

- Please remember that parents **must provide any over-the-counter medicines** they anticipate their child may need.

***If your child requires an Epi-pen or other injection, please contact the Farm School Nurse at 205-387-1806 ext. 125 or farmnurse@campmcdowell.com*

Kathy Snoddy, R.N.
McDowell Farm School

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Medication Packing Sheet *for Parents*

Please place this sheet in a bag with your child's medicine. All information must be completed by a parent or legal guardian. Please fill out the information for prescription and over the counter medicines.

Student's Name:____________________________________ School:______________________________

PRESCRIPTION MEDICATIONS:

Circle the 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
*If a time is not selected, medicines will be given after breakfast.

Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS**
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<u>OVER THE COUNTER (OTC) MEDICATIONS:</u> ALL OTC MEDICATIONS MUST BE PROVIDED BY PARENTS/LEGAL GUARDIANS OF THE STUDENT. Circle "As Needed Only", if medication is not taken daily.

Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**
Medication:	Dosage:	Reason:	Time Given: **B* B L C D HS** **As Needed Only**

Waiver of Liability & Release

This form must be completed for every participant in a Camp McDowell program.
Please read carefully before signing.

PROGRAM DESCRIPTION

All of Camp McDowell's programs ("Programs") take place in an area that includes over 1,000 acres of forests, meadows, streams, and canyons. The Programs involve physical and hazardous activities that take place in this wilderness and outdoor camp environment, including without limitation, swimming; canoeing; hiking over rough terrain or in the vicinity of water; and challenge or ropes course activities such as climbing, jumping, balancing, and being lifted or supported by a rope and harness system at heights up to thirty feet in the air.

ASSUMPTION OF RISK AND AGREEMENT TO RELEASE AND HOLD HARMLESS

I, the undersigned, understand and agree that participating in any Program inherently involves risks, hazards, and dangers, including but not limited to the risks of falling, falling rocks or objects, fractures, concussions, dangerous weather, overexertion, overheating, injuries caused by a lack of fitness or conditioning, river currents, hypothermia, hostile or aggressive farm animals or wildlife, equipment failures, negligence of others, accident, injury, death, mental or emotional trauma, disability, and property damage or loss. In consideration for my being permitted to participate in a Program, I, for myself (and for my child if participant is under 19), my heirs, assigns, and personal representatives, hereby knowingly and intentionally agree to assume all risks of participating in any Program and forever release and hold harmless Camp McDowell and the Episcopal Diocese of Alabama, as well as their employees, agents, directors, volunteers, participants, guests, representatives, affiliates, and all other persons or entities acting under their direction and control ("Released Parties") from any and all liability, claims, actions, losses, and demands arising out of or relating in any way to my participation in any Program, including but not limited to those arising from travel to and from the program site or from the negligence of the Released Parties.

By signing this form I am certifying that I am capable of—and have not been advised by a medical professional to refrain from—participating in these and similar physical activities. I also consent to receive (or, if applicable, have my child receive) medical treatment that may be deemed advisable in the event of injury, accident, or illness during any Program.

This agreement is governed by and shall be construed in accordance with the laws of the state of Alabama, without any reference to its choice of law rules. I agree that any dispute arising from this agreement or in any way associated with a Program shall be brought only in the state or federal courts of Jefferson County, Alabama, and I agree to the jurisdiction and venue of those courts for any such dispute.

I HAVE CAREFULLY READ, FULLY UNDERSTAND, AND VOLUNTARILY SIGN THIS WAIVER OF LIABILITY AND RELEASE ON BEHALF OF MYSELF AND, IF APPLICABLE, AS THE PARENT OR LEGAL GUARDIAN OF A PROGRAM PARTICIPANT UNDER THE AGE OF 19 YEARS.

_____ _____

Name of Program Participant Date

_____

Signature of Participant (If 19 Years or Older)

_____

Signature of Parent or Legal Guardian (If Participant Under 19 Years)