*******PLEASE KEEP THIS SHEET FOR YOUR REFERENCE*******

KIRTLAND MIDDLE SCHOOL 6TH GRADE CAMP
NURSES NOTES TO PARENTS

Please complete Emergency Medical Information on your child, and include any recent illnesses or injuries, allergies and needed medications.

Regarding Medicines:

- Please fill out enclosed Medication Sheet for any medicines.
- Parent MUST supply ALL medications that may be needed for the whole week. Each must be in original, labeled container.
- Please place all medicines in a Ziploc type bag with student name on bag as well as on each medicine bottle/box inside.
- Any prescription medication or herbal supplements must have a DOCTOR'S order along with parent signature.
- Any non-prescription/ over-the counter medicines must have parent signature and explanation for use.
- Please be sure to give specific DOSE, TIMES OF DAY, and REASON for use (ex: headaches, fever, cramps, stomach ache, etc.)
- If your child has ASTHMA, is proficient in using an inhaler, and is responsible enough….Dr and parent may give the student permission to carry and administer inhaler as directed. This may be an important time-saver during an asthma attack at camp as some of the activities may be 20 minutes from the nurse's cabin.

Other Things to Consider:

- Meal times are approximately 8:00am, 12:00, 5:30pm, and a snack at 9pm
- If your child wears glasses, please tighten screws before camp.
- If your child wears contacts, please send solution and a backup pair of glasses.
- Please have your child wear old, comfortable shoes and clothes, and high socks (above ankles!), for walking and hiking.
- Please let us know if your child has any special dietary needs. I may be able to store needed items.

*****ALL MEDICINES (NON PRESCRIPTION OR PRESCRIPTION) WILL BE COLLECTED ON THE MORNING THAT WE LEAVE FOR CAMP. NO MEDICINES ARE TO BE PACKED IN YOUR CHILD'S LUGGAGE.***

If you have any questions or concerns please feel free to call me during school hours, or leave a message, 256-3358, ext. 3003.

Thank you, Kim Crawford, RN

*****ALL MEDICAL FORMS NEEDED TO BE COMPLETED AND RETURNED TO MR. MORAN BY FRIDAY, MAY 6TH, 2011***

6TH GRADE CAMP – EMERGENCY AND MEDICAL INFORMATION

Student's Name:____Date of Birth:____________

Parents' Names:____

Address:__________________________________Home Phone:________________________

Student lives with: ____

Other phone numbers for parents / guardians:

Name: _________________Work:__________________Cell:_________________________

Name:__________________Work:__________________Cell:_________________________

Alternate to call in case of emergency:

Name:____________________________________ Phone Number:________________

Relationship to student:____

Family Doctor's Name:______________________Telephone Number:___________________

Allergy - to any food or medication:____

to anything else (seasonal / animal / stings…):_______________________________________

**TREATMENT for allergy:____

Medical Conditions:____

Asthma:____

Any physical disability, impairment or limitation?_____________________________________

Any recent illness or injury?____

Medications taken (Please fill out medication form):__________________________________

____

I give my permission for my child to participate in this activity and to receive adequate medical attention if needed. I confirm that my child is covered by some form of insurance for any injury which might occur while participating in this field trip.

Insurance Information:____

Parent's Signature:____**Date:**_____________

.....PLEASE COMPLETE BOTH SIDES.....

HAS THE CAMPER / DOES THE CAMPER (IF YES PLEASE PROVIDE ADDITIONAL INFORMATION):

Had any recent infectious disease? ☐ Yes ☐ No ______________________________

Have a chronic or recurring illness or infection? ☐ Yes ☐ No ______________________

Have frequent headaches? ☐ Yes ☐ No ___________________________________

Ever had a head injury / knocked unconscious? ☐ Yes ☐ No ____________________

Ever seizure? ☐ Yes ☐ No ____

Had fainting or dizziness during or after exercise? ☐ Yes ☐ No __________________

Ever had chest pain with exercise? ☐ Yes ☐ No ______________________________

Ever been diagnosed with a heart murmur? ☐ Yes ☐ No _______________________

Ever had back problems? ☐ Yes ☐ No ____________________________________

Ever had problems with joints (knees/ ankles)? ☐ Yes ☐ No ____________________

Have any skin problems (itching, rash, acne, eczema)? ☐ Yes ☐ No ______________

Have problems with falling asleep / sleepwalking? ☐ Yes ☐ No __________________

Have urinary issues? ☐ Yes ☐ No ____________Bedwetting? ☐ Yes ☐ No ___________

Have stomach aches? ☐ Yes ☐ No ____________ Diarrhea / Constipation? ☐ Yes ☐ No ___

History wheezing / asthma / shortness of breath? ☐ Yes ☐ No ___________________

If female: problems with menstrual cycle?______________________________________

Wear glasses or contacts?______________________(Please bring extra pair or backup glasses)

Wear braces?____________________Bringing an orthodontic appliance?_____________________

Any additional information about the camper's behaviors, physical or emotional health about which we may need to be aware:____

____

____

KIRTLAND SCHOOLS

Requests for Medications to be given on Field Trips and Tours

Student Name: ________________________________ Grade: __________

Address: ________________________________ Zip: __________

NON-PRESCRIPTION MEDICATIONS

TO BE COMPLETED BY PARENT / GUARDIAN:

I hereby request that the following non-prescription medications may be given:

Medications	Dosage	Frequency / Time of Day	Purpose

Dates to be given: ________________________________

PRESCRIPTION MEDICATION

TO BE COMPLETED BY THE PHYSICIAN:

Medications	Dosage	Frequency / Time of Day	Purpose

Dates to be given: ________________________________

Any possible reactions that, if they occur, should be reported to the physician:__________

____

Any special instructions: (storage, with food, etc…)________________________________

Physician Name: ________________________________

Address:________________________________Phone: __________

Physician Signature: ________________________________ **Date:** __________

I request the above medication to be given to my child, as ordered by Dr.__________

Parent / Guardian Signature:________________________________ **Date:** __________

****Please note: Any medications brought in must be in the original, labeled container. ****

Meds Administered

Medication	Dose	Time	Monday	Tuesday	Wednesday	Thursday	Friday