Medical Emergency Authorization Form & Health Plan

I _____, the parent or legal guardian of _____, a minor,

who is participating in the Community Schools Outdoors program. I authorize program staff to make decisions regarding the emergency care or treatment of above named child**, including seeking and approving medical treatment for non-emergencies** in the event I cannot be reached.

_____ _____ _____

Parent Printed Name Parent Signature Date

Health Plan

Any participant in a Community Schools Outdoors program requiring medications or health care products such as, but not limited to; prescription, over-the-counter, homeopathic, essential oils, herbal supplements, etc.
ON A DAILY BASIS Is REQUIRED to complete this Health Plan
and turn it into staff no later on the Monday that camp begins.
No child will be allowed to participate in the program if they require medications or health care products that have not been reported to us.
No participant may carry any medications or health care products
EXCEPT: Inhalers for breathing conditions and Epi-Pens for extreme allergic reactions.
All other medications & health care products will be carried and distributed by staff members.

DAILY DOSAGES

If your child will require medication or other health care products during the event, the staff member acting as the nurse will carry and administer the products. All products must be given to the Lead Guide on the 1st day of camp. Inhalers/Epi-Pens must also be registered. All products must be in the original packaging.

DAILY MEDICATION OR OTHER HEALTH CARE PRODUCT INFORMATION

Name of Product to be taken:	Condition for which product is taken:	Dosage Schedule: (e.g. 2 in the AM, 2 in the PM with food)

If dosages are different than labeled on the package, a doctor's explanation and signature are required here:
Physician's Explanation:

Physician's Signature: _____

Over >

Student Name: _____

OVER THE COUNTER MEDICATION

Staff will carry these over-the-counter products for all campers.
May they be administered to your child during the program?

PLEASE MARK EITHER **YES or NO**

Acetaminophen	⌗ YES	⌗ NO
Ibuprofen	⌗ YES	⌗ NO
Topical Anti-Itch Cream	⌗ YES	⌗ NO
Anti-Diarrhea Medication	⌗ YES	⌗ NO
Pepto Bismol	⌗ YES	⌗ NO
Antacids	⌗ YES	⌗ NO
Gas Relief	⌗ YES	⌗ NO
Antibiotic Cream	⌗ YES	⌗ NO
Saline Eye Rinse	⌗ YES	⌗ NO
Motion Sickness Aid	⌗ YES	⌗ NO
Common Cold Medication	⌗ YES	⌗ NO
Antihistamines (Benadryl)	⌗ YES	⌗ NO
Rehydration Tablets	⌗ YES	⌗ NO

Parent Signature:_____