Greenkill Outdoor Environmental Education Center

2011-2012 Program Participation & Health Form

Carol Nivens RN

School ______________________ Dates of Greenkill Experience: ______________

Students Name: ____ Male / Female (*Please circle*)
Last First MI

Age: __________ Birth date: __________ Greenkill Birthday! Yes / No (*Please circle*)

Contact information:

Name of Parent/Guardian: ______________________ Relationship: ______________

Home Address ____
Street Apt.# City State Zip

Home:( ) ____________ Work:( ) ____________ Cell:( ) ____________

Name of Emergency Contact: ______________________ Relationship: ______________

Home:( ) ____________ Work:( ) ____________ Cell:( ) ____________

Food / Dietary Needs: ____

Please notify and talk with the school regarding dietary needs. The school will coordinate with Greenkill to ensure each students needs are met.

Health Concerns: It is extremely important that the school be advised of any/all health care matters regarding your child. Please note here any information that will be important for the Greenkill instructional staff to be aware of in order for them to provide a safe and positive experience for your child: ____

____

Limited participation: Please understand that the students will be participating in Outdoor Environmental Education program which will include some physical activities, it is important to inform school of any activities which your child should not, or might have difficulty participating in:

____

Has this student ever required any psychiatric counseling or hospitalization? Yes / No (*Please circle*)

Explain ____

Name of family physician ______________________ Phone ______________________

Do you carry family medical/hospital insurance? _____ Yes _______ No

If yes, indicate: Carrier ______________________ Policy or Group # ______________________

Emergency Authorization REQUIRED

This health history is correct so far as I know, and the person herein described has permission to engage in all activities in the Greenkill Outdoor Environmental Education at YMCA Camping Services program except as noted above. **Permission to Treat**: I hereby give permission to the medical personnel selected by the school and/or YMCA to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the school and/or YMCA to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian: ______________________ **Date:**

PHYSICIAN—PLEASE FILL OUT BOTH PARTS!!

For medications to be dispensed by a NURSE the following must be completed by the licensed health care prescriber AND signed by parent/guardian:

THIS IS FOR PRESCRIPTION MEDS AND OVER THE COUNTER MEDICATIONS!!!!

I request that my patient receive the following **prescription medication**(s) including **OVER THE COUNTER AND PRN MEDS:**

Name of student: ______________________ Date of Birth: ______________________

Diagnosis: ____

Name of Medication(s) with the prescribed dosage, frequency and route of administration:

1). ____

2). ____

3). ____

4). ____

Standard Over the Counter Medications—BLANKS MUST BE FILLED ("NOT AS DIRECTED")

The following medications are available in the Health Center with parent/guardian AND physicians order. Please select which medications below can be administered and fill in the blanks.

Drug Name	Route	Dosage	Schedule	Indication	Comments
Motrin / Ibuprofen	PO (Chewable tabs, pills or liquid)	________mg	Every________hours	For pain or fever	
Tylenol /Acetaminophen	PO (Chewable tabs, pills or liquid)	________mg	Every________hours	For pain or fever	
Claritin	PO	________mg	Every________hours	For allergy symptoms	
Benadryl / Diphenhydramine	PO (pills, liquid)	________mg	Every________hours	For allergy symptoms	
Zyrtec	PO	________mg	Every________hours	For allergy symptoms	
Calamine lotion/gel	Topical		Every________hours	For bug bites and skin irritations	
Bacitracin ointment	Topical		Every________hours	For splinters, cuts, abrasions and skin irritations	

Licensed Physician's Signature ______________________ License # ______________

Address ______________________________________ Phone (   ) ______________

Date of Form Completion __________ By ______________________

Initial if completed by nurse or physician's assistant

I agree with the above medications and dosages to be administered to my child.

Parent / Guardian Signature ______________________ Date __________