Explorer West Middle School Emergency Data and Release Form - Student Information – 2010/2011

Please use blue or black ink and print clearly. This information is sent out with leaders on all outdoor education trips.

Student Name: ____**Grade**: ________**Birthdate**: ___________________

Address: ____

City: _________________________________State: _________ Zip: ______________ Home Phone: _______________________________

Parent/Guardian #1

Name: ____

Address: ____

____

Home Phone: ____

Work name & phone #___________________________________

E-mail address:____

Cell Phone: ____

Parent/Guardian #2

Name: ____

Address: ____

____

Home Phone: ____

Work name & phone #___________________________________

E-mail address:____

Cell Phone: ____

ONE EMERGENCY # FOR PHONE TREE: Contact name Number
Please circle one: cell home work

Emergency Contact ____________________________________ Cell #: _____________________Home#: _________________________

Address: ____Work Phone: ________________________________

Physician name/phone/address____

____

Medical Insurance Name/Policy/Group #: ____Insurance Phone #_____________________________

Please note that if your student takes oral medication(s), you must complete the form "**Authorization for Administration of Oral Medication at School".**
Does this student have any physical disabilities, allergies, drug reactions or other unusual conditions that may limit her/his activity of which Explorer West Middle School should be aware? _____ **YES** _____ **NO**

If yes, please list condition, allergy, or restrictions:

____

____

Hospital preference: ____ Hospital Phone: ___________________________________
(In the event of medical emergency)

RELEASE: I hereby authorize Explorer West Middle School to have medical professionals provide emergency treatment for my child in the event I cannot be contacted, and I agree to assume financial responsibility for such treatment.

Signature of Parent(s) or Guardian(s):

Parent/Guardian #1 ____ Date _____________

Parent/Guardian #2 ____ Date _____________

FOR OFFICE USE ONLY: _____ Field Trip and School Program Permission Form _____ Outdoor Education Program Release of Liability
_____Certificate of Immunization Form _____Physical Examination Form _____ Authorization for Administration of Oral Medication at School

2010-2011
Explorer West Middle School
Field Trip and School Program Permission Form
and Acknowledgment of Risk

Student name: ____

I/We, ____, parent/legal guardian, do hereby give my/our permission for my/our child to participate in all field trips and school programs sponsored by Explorer West Middle School for the academic year 2010-2011, which may include:

- Co-ed Physical Education (either on or off campus): soccer, basketball, racquet sports, track and field, softball, volleyball and others
- Community-service activities, and local field trips
- After-school sports and clubs including track and field, basketball, soccer, ultimate frisbee, and volleyball

I/We acknowledge that there are certain risks inherent in field trips and various school programs, and that all risks cannot be prevented, including the risks associated with transporting students by car, bus or ferry to and from various activities, and the risks involved in the activities or programs themselves.

I/We represent that my/our child is physically able, with or without accommodations, to participate in all field trips or programs. If during the school year my/our child's physical condition changes, I/we agree to provide the Head of School with written notice of any restriction and/or limitations at least two (2) days in advance of any scheduled program or field trip.

I/We acknowledge that Explorer West Middle School's accident insurance for field trip participants is limited and should not be relied upon as the primary reimbursement for medical expenses arising from field trip participation. I/We agree and understand that parents should provide independent insurance. I/We also agree to be financially responsible for all medical expenses incurred which are not covered by my/our insurance.

I/We authorize Explorer West staff or trip leaders to administer emergency medical care, including the administration of oral medications, as deemed necessary by such staff or trip leaders.

I/We have received a copy of the school's policies, standards, and expectations for behavior (written in the Parent/Student Handbook), and I/we understand that all of said policies, standards, and expectations apply during all school field trips and programs. If, in the judgment of the school's leader(s), my/our child has engaged in behavior that is detrimental to or incompatible with the interest, harmony, or welfare of Explorer West Middle School, its other participants, or the community, he or she will be sent home.

Being aware of the inherent risks involved in participating in school programs, I/we agree to allow my/our child to participate in Explorer West Middle School's programs and field trips.

Parent/guardian #1 signature ____________________________________ **Date:** ___________

Parent/guardian #2 signature ____________________________________ **Date:** ___________

Explorer West Middle School is fully committed to providing reasonable accommodations to its students, to enable them to fully engage in the educational process. All accommodation requests should be made to the Head of School to help protect the student's privacy.

Explorer West Middle School
2010-2011 Outdoor Education Program
Release of Liability and Indemnification Agreement

I/We, ___________________________________, hereby consent to the participation of my/our child, __________________________, in Explorer West Middle School's Outdoor Education Program. Explorer West Middle School's Outdoor Education Program includes any act or event occurring during the course of preparing for, participating in, termination of, and returning from Explorer West Middle School's Outdoor Education Program.

I/We understand that Explorer West Middle School is permitting my/our child to participate in the Outdoor Education Program in consideration for my/our entering into this Release of Liability and Indemnification Agreement.

I/We have been informed of the nature of the program by reviewing the attached Outdoor Education program materials. I/We understand that the Outdoor Education Coordinator is available to answer any specific questions I/we may have about the program. I/We understand that there are inherent risks in the Outdoor Education Program, including (but not limited to) risks related to:

- Transportation to and from camps and program activities by motor vehicles
- Acts of nature
- Acts of fellow participants, or program staff or instructors
- Activities in or around streams, rivers, the ocean, or other bodies of water
- Animals, insects, spiders and plants
- Camp food
- Fire
- Exposure to the weather, including sun, heat and cold
- Uneven and slippery surfaces
- Unpatrolled or non avalanche controlled backcountry terrain
- Wilderness travel (defined as greater than or equal to one hour away from professional medical care)
- Athletic and other physical activities, including some which could be considered to be inherently dangerous
- Other risks known or unknown

I/We attest that my/our child is in good health and has no physical condition that would prevent or hinder his or her participation (with reasonable accommodation) in Explorer West Middle School's Outdoor Education Program. I/we further attest that we have provided to Explorer West Middle School all information about any medical situations (allergies, needs for medication, pre-existing conditions) which exist and may require attention or awareness during the Outdoor Education Program. In the event of an emergency, I/we hereby grant permission for Explorer West Middle School, as it deems necessary and appropriate, to seek emergency aid and/or treatment for my/our child and I/we agree to pay the costs of any such emergency aid or treatment. I/we understand that Explorer West Middle School staff and/or chaperones who accompany the Outdoor Education Program will make a reasonable effort under the circumstances to reach me/us prior to arranging for emergency medical treatment for my/our child.

I/We understand that, in order for our child to take any medications (even those usually taken by my/our child at home) I/we will need to provide Explorer West with a physician's order as provided on the form "Authorization for Administration of Oral Medication at School". However, in an emergency, I/we permit Explorer West staff or trip leaders to administer emergency care as they deem necessary, including the administration of oral medications.

I/We acknowledge that Explorer West Middle School's accident insurance for participants in the Outdoor Education Program is limited and should not be relied upon as the primary reimbursement for medical expenses arising from participation in the Outdoor Education Program. I/We agree and understand that parents should provide independent insurance. I/We also agree to be financially responsible for all medical expenses incurred which are not covered by my/our child's plan or by Explorer West's policy.

I/We have received a copy of the school's policies, standards, and expectations for behavior (written in the Parent/Student Handbook), and I/we understand that all of said policies, standards, and expectations apply during all school field trips and programs. If, in the judgment of the school's leader(s), my/our child has engaged in behavior that is detrimental to or incompatible with the interest, harmony, or welfare of Explorer West Middle School, its other participants, or the community, he or she will be sent home at my/our expense.

In consideration for permitting my/our child to participate in the Outdoor Education Program in light of the known and unknown risks, I/we freely and voluntarily agree to assume all risks, known or unknown (other than the risk of gross negligence by Explorer West Middle School) associated with my/our child's participation in Explorer West Middle School's Outdoor Education Program, and further agree to defend, indemnify, and hold harmless Explorer West Middle School, together with its past, present, and future administrators, trustees, volunteers, employees, and other agents or representatives, against all liability, claims or damages (including claims for costs and attorneys' fees) arising out my/our child's participation in Explorer West Middle School's Outdoor Education Program, even if caused solely by the negligence (other than gross negligence) of Explorer West Middle School, its employees, volunteers, or other agents or representatives.

I/We further agree to defend, indemnify, and hold harmless Explorer West Middle School, its past, present, and future administrators, trustees, volunteers, employees, and other agents or representatives, against all liability, claims or damages arising out of Explorer West Middle School's Outdoor Education Program, including any claims made by others for personal injury or property damage allegedly caused by us or by my/our child, or any claims made on behalf of my/our child in light of his or her status as a minor.

This agreement contains the entire agreement between the parties and supersedes any prior agreement whether oral or written on the subject of liability, indemnification, waiver or release of claims related to participation in Explorer West's Outdoor Education Program. Any amendment or change to the Agreement must be made in writing and signed by both parties.

I/We have had the opportunity, if I/we chose to use it, to review this Agreement with legal counsel and have been encouraged by Explorer West Middle School to do so.

This Agreement shall be binding upon my/our and my/our child's heirs, representatives, successors, and assigns, effective as of the date indicated below.

I/WE HAVE READ AND UNDERSTOOD THIS AGREEMENT BEFORE SIGNING IT. (BOTH PARENTS MUST SIGN UNLESS OTHERWISE APPROVED BY EXPLORER WEST MIDDLE SCHOOL.)

____
Signature of Parent

Date: __________________________

____
Signature of Parent

Date: __________________________

____
Name of Student

ACCEPTED:

EXPLORER WEST MIDDLE SCHOOL

By:_____________________________

Its: _____________________________

Date: ___________________________

Explorer West Middle School is fully committed to providing reasonable accommodations to its students, to enable them to fully engage in the educational process. All accommodation requests should be made to the Head of School to help protect the student's privacy.

EXPLORER WEST MIDDLE SCHOOL
Concussion Information Sheet and Acknowledgement Form

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:	
• Headaches • "Pressure in head" • Nausea or vomiting • Neck pain • Balance problems or dizziness • Blurred, double, or fuzzy vision • Sensitivity to light or noise • Feeling sluggish or slowed down • Feeling foggy or groggy • Drowsiness • Change in sleep patterns	• Amnesia • "Don't feel right" • Fatigue or low energy • Sadness • Nervousness or anxiety • Irritability • More emotional • Confusion • Concentration or memory problems (forgetting game plays) • Repeating the same question/comment

Signs observed by teammates, parents and coaches include:
• Appears dazed • Vacant facial expression • Confused about assignment • Forgets plays • Is unsure of game, score, or opponent • Moves clumsily or displays incoordination • Answers questions slowly • Slurred speech • Shows behavior or personality changes • Can't recall events prior to hit • Can't recall events after hit • Seizures or convulsions • Any change in typical behavior or personality • Loses consciousness

EXPLORER WEST MIDDLE SCHOOL
Concussion Information Sheet and Acknowledgement Form

What can happen if my child keeps on playing with a concussion or returns to soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athlete will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The new "Zackery Lystedt Law" in Washington now requires the consistent and uniform implementation of long and well-established return to play concussion guidelines that have been recommended for several years:

> "a youth athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time"
>
> and
>
> "…may not return to play until the athlete is evaluated by a licensed heath care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider".

You should also inform your child's coach if you think that your child may have a concussion Remember its better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/

________________________ ________________________ __________

Student-athlete Name Printed **Student-athlete Signature** **Date**

________________________ ________________________ __________

Parent or Legal Guardian Printed **Parent or Legal Guardian Signature** **Date**

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 6/15/2009

EXPLORER WEST MIDDLE SCHOOL
PHYSICAL EXAMINATION FORM
For 2010/2011

TO BE FILLED OUT BY YOUR CHILD'S PHYSICIAN

STUDENT'S NAME: ____**Date of Birth:** ___________________

Age: ________________ Pulse: _______________

Height: _______________Blood Pressure: ______________

Weight: _______________Visual Acuity: Left 20/_______
Right20/_______

Optional

Urinalysis:

Body Fat %
HCT:

EST VO2 Max:

Audiometry:

Normal			Abnormal	
__	1.	Head	__	____________________________________
__	2.	Eyes (pupils), ENT	__	____________________________________
__	3.	Teeth	__	____________________________________
__	4.	Chest	__	____________________________________
__	5.	Lungs	__	____________________________________
__	6.	Heart	__	____________________________________
__	7.	Abdomen	__	____________________________________
__	8.	Genitalia	__	____________________________________
__	9.	Neurological	__	____________________________________
__	10.	Skin	__	____________________________________
__	11.	Physical Maturity	__	____________________________________
__	12.	Spine, back	__	____________________________________
__	13.	Shoulders, Upper Extremities	__	____________________________________
__	14.	Lower extremities	__	____________________________________

Assessment: ____ Full participation
____ Limited participation (describe limitations, restrictions): _______________________
____
____
____
____ Participation contraindicated (list reasons):
____
____

Recommendations (equipment, taping, rehabilitation, etc.): ______________________________
____
____

DATE: _____________ **EXAMINER'S SIGNATURE** _______________________________

EXAMINER'S PHONE: ________________________________

PRINT EXAMINER'S NAME CLEARLY: ____

Examiner's office address: ____

Page two – continued on back

2010-2011
EXPLORER WEST MIDDLE SCHOOL
PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION FORM

***For Student/Parent to complete prior to exam and to submit to Physician for assessment.**

Name: ____ **Birth Date:** ________________**Exam Date:**________________

Address: ___________________________________**City:** _____________________________**Zip Code:** ________________

Phone: _____________________________ **Sports I plan to participate in:** ____

	Yes	No	**PATIENT HISTORY**
1.a.	__	__	Have you had any illness/injury, recently, or do you have an illness/injury now?
b.	__	__	Have you had a medical problem, illness or injury since your last exam?
c.	__	__	Do you have any chronic or recurrent illness?
d.	__	__	Have you ever had any illness lasting more than a week?
e.	__	__	Have you ever been hospitalized overnight?
f.	__	__	Have you had any surgery other than a tonsillectomy?
g.	__	__	Have you ever had any injuries requiring treatment by a physician?
h.	__	__	Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
2.	__	__	Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc?)
3.	__	__	Do you have ANY allergies (medicines, bees, foods other factors)?
4.a.	__	__	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
b.	__	__	Do you tire more easily or quickly than your friends during exercise?
c.	__	__	Have you ever had any problem with your blood pressure or your heart?
d.	__	__	Have any close relatives had heart problems, heart attack or sudden death before age 50?
5.	__	__	Do you have any skin problems (acne, itching, rashes, etc)?
6.a.	__	__	Have you ever had fainting, convulsions, seizures, or severe dizziness?
b.	__	__	Do you ever have frequent severe headaches?
c.	__	__	Have you ever had a “stinger” or “burner” or “pinched nerve”?
d.	__	__	Have you ever been “knocked out” or “passed out”?
e.	__	__	Have you ever had a neck or head injury?
7.	__	__	Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
8.	__	__	Have you had asthma, or trouble breathing, or cough during or after exercise?
9.a.	__	__	Do you wear eyeglasses, contact lenses or protective eyewear?
b.	__	__	Have you had any problems with your eyes or vision?
10.	__	__	Do you wear any dental appliance such as braces, bridge, plate retainer?
11.a.	__	__	Have you ever had a knee injury?
b.	__	__	Have you ever had an ankle injury?
c.	__	__	Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
d.	__	__	Have you ever had a broken bone (fracture)?
e.	__	__	Have you ever had a cast, splint, or had to use crutches?
f.	__	__	Must you use special equipment for competition (pads, braces, neck roll, etc.)?
12.	__	__	Has it been more than 5 years since your last tetanus booster shot?
13.	__	__	Are you worried about your weight?
14.	__	__	FEMALES: Have you have any menstrual problems?
15.	__	__	Have you any medical concerns about participating in your sport?

**********ATHLETE SHOULD NOT WRITE BELOW THIS LINE***********

EXAMINER’S COMMENTS ON ALL “YES” ANSWERS (Please refer to question number):

Reviewed by: Staff Signature	Date:	Is there an accompanying signed Certificate of Exemption on file? ❑ Yes ❑ No

DOH 348-013
Rev: 10/15/08

Certificate of Immunization Status (CIS)

Child's Last Name:	First Name:	Middle Initial:	Child's Address:
Child's Birthdate:		Child's Sex:	
Parent/Guardian Name:			Parent/Guardian Day Phone:

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.

◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only

Vaccine	Dose	Date	Age
◆ Hepatitis B (Hep B)			
	1		
	2		
	3		
Hepatitis B (Hep B) Alternate schedule for teens			
	1		
	2		
Rotavirus			
	1		
	2		
	3		
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)			
	1		
	2		
	3		
	4		
	5		
◆ Diphtheria, Tetanus, Pertussis (Tdap, Td)			
	1		
	2		
● *Haemophilus influenzae* type b (Hib)			
	1		
	2		
	3		
	4		

See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.

Vaccine	Dose	Date	Age
● Pneumococcal (PCV, PPV)			
	1		
	2		
	3		
	4		
◆ Polio (IPV, OPV)			
	1		
	2		
	3		
	4		
Influenza (most recent)			
◆ Measles, Mumps, Rubella (MMR)			
	1		
	2		
◆ Varicella (chickenpox)			
	1		
	2		

Vaccine	Dose	Date	Age
Hepatitis A (Hep A)			
	1		
	2		
Meningococcal (MCV4, MPSV4)			
	1		
Human Papillomavirus (HPV)			
	1		
	2		
	3		
Other			

I certify that the information provided here is correct and verifiable.

Signature of Parent or Guardian Date

▼ Verification of varicella disease history ▼

❑ Health Care Provider (HCP) Verified ▶	❑ Signed note from HCP attached **or** ❑ HCP provider signature here: ▶	**Licensed HCP Signature (MD, DO, ND, PA, ARNP) Date**
❑ HCP Verified by Registry ▶	No HCP Sig required if box at left checked. **If school staff find verification in the Registry, then school staff must:** ▶	**Either** initial with parent approval or get parent signature below: Staff initials indicating parent approval: ______
❑ Parental Report ▶	**ONLY** acceptable for some grades. Write date or age child had disease:	Parent Signature indicating approval: ______

Documentation of Immunity by Blood Test (titer)

I certify that the child named on this form has laboratory evidence of immunity to (check all that apply):

☐ Diphtheria ☐ Hepatitis A ☐ Hepatitis B ☐ Hib ☐ Measles ☐ Mumps ☐ Polio ☐ Rubella ☐ Tetanus ☐ Varicella

☐ Other (list): ☐ lab report(s) attached (required)

X

Typed or Printed Name of **Licensed Health Care Provider** (MD, DO, ND, PA, ARNP)

X

Signature of **Licensed Health Care Provider** (required) Date (required)

Vaccine Trade Names*

Read down and across - Trade Names are in Alphabetical Order.

Trade Name	Vaccine	Trade Name	Vaccine
Acel-Imune	DTaP	Menomune	MPSV4
ActHIB	Hib	OmniHIB	Hib
Adacel	Tdap	Pediarix	DTaP + IPV + Hep B
Boostrix	Tdap	PedvaxHIB	Hib
Certiva	HPV	Pentacel	DTaP + IPV + Hib
Comvax	Hib + Hep B	Pentavalente	DTaP + Hep B + Hib
Daptacel	DTaP	Pneumovax	PPV23
Decavac	Td	Prevnar	PCV or PCV7
Engerix-B	Hep B	ProHIBiT	Hib
Fluarix	Flu	ProQuad	MMRV
FluMist	Flu	Quadracel	DTaP + IPV
Fluvirin	Flu	Recombivax	Hep B
Fluzone	Flu	Rotarix	Rotavirus
Gardasil	HPV	RotaTeq	Rotavirus
Havrix	Hep A	Tetramune	DTP + Hib
HibTITER	Hib	TriHIBit	DTaP + Hib
HyperTET	TIG	Tri-Immunol	DTP
HyperHEP B	HBIG	Tripedia	DTaP
Ipol	IPV	Twinrix	Hep B + Hep A
Infanrix	DTaP	Vaqta	Hep A
Kinrix	DTaP + IPV	Varivax	Varicella
Menactra	MCV4		

Vaccine Abbreviations*

Read down – Abbreviations are in Alphabetical Order.

Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus
DTaP	Diphtheria, Tetanus, acellular Pertussis
DTP	Diphtheria, Tetanus, Pertussis
Flu (TIV or LAIV)	Influenza
HBIG	Hepatitis B Immune Globulin
Hep A (HAV)	Hepatitis A
Hep B (HBV)	Hepatitis B
Hib	*Haemophilus influenzae* type b
HPV	Human Papillomavirus
IPV	Inactivated Poliovirus Vaccine
MCV4	Meningococcal Conjugate Vaccine
MPSV4	Meningococcal Polysaccharide Vaccine
MMR	Measles, Mumps, Rubella
MMRV	Measles, Mumps, Rubella, Varicella
OPV	Oral Poliovirus vaccine
PCV or PCV7	Pneumococcal Conjugate Vaccine
PPV23	Pneumococcal Polysaccharide Vaccine
Rota (RV1 or RV5)	Rotavirus
Td	Tetanus, Diphtheria
Tdap	Tetanus, Diphtheria, acellular Pertussis
TIG	Tetanus immune globulin
VAR or VZV	Varicella

***These lists may not be comprehensive; visit http://www.doh.wa.gov/cfh/immunize/forms/default.htm for updated lists.**

Explorer West Middle School
Authorization for Administration of Oral Medication at School 2010-2011

Student's Name ____

Birth Date ______________________________ Grade ____________________

This portion to be completed by the Licensed Health Care Provider within their prescriptive authority.

Name of Medication	Dosage	Method of Administration	Time of Day to be Taken
____________	______	______________	____________
____________	______	______________	____________

Diagnosis or reason for medication ____________________________________

____

If given PRN, specify the length of time between doses ___________________________

Inhalers: ____
Indicate if student carry on his/her person

Student is capable of self-administration of medication ________ Yes _________ No

Possible side effects of medication ____________________________________

Emergency procedure in case of serious side effects ___________________________

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period from ____________________ (date) to __________________ (date), not to exceed current school year, as there exists a valid health reason which make administration of the medication advisable during school hours. Such medication may be administered by medically untrained school personnel.

______________________ ______________________
Date of Signature Licensed Health Care Provider's Signature

______________________ ______________________
Telephone Number Name

This portion to be completed by the Parent/Guardian

I request/authorize the school to administer medication to the above identified student in accordance with the LHP's instructions for the period from __________________ to __________________ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Medication will be supplied to the school in the original container.

Permission to carry inhaler ________ Yes ________ No

Permission to self-administer medication _______ Yes _______ No

______________________ ______________________
Date of Signature Parent/Guardian Signature

Telephone Number _____________ (home) __________________ (work)

4/20/2010