Outdoor Educational Experience at Camp Waskowitz

Medications and paperwork are due ***Friday, February 26th 2016***

In order to meet the health needs of your student camper, carefully read the following information:

1. **All medications,** including over-the-counter medication (pain relievers, antacids, antihistamines, etc.) **must be accompanied by signed physician's orders and signed parental permission forms** [Washington State Law-RCW 28.210.260]. In most cases, this will be the Camp Waskowitz Medication Authorization Form. However, if your child already has a signed RSD Medication Authorization form completed at school with an Epi-pen or inhaler, we will bring that form and medication along and the Camp will honor our document.

2. All medication will be kept secure by a designated staff member. An exception may be made for medications ordered to be carried by the staff or student, so as to be immediately available to students with life-threatening health conditions.

3. Students who currently have medication dispensed at school: if there are additional doses needed within the 24 hour period, the parent is responsible for obtaining and providing physician's orders on a Camp Waskowitz Medication Authorization Form, reflecting the *complete daily dosage schedule* and enough medicine for the entire camp stay (medications for ADHD, for example).

4. Please turn in signed medication forms ***and*** properly labeled medication to the school nurse by **Friday, February 26th, 2016**.

5. For the sake of convenience and safety, please send only that medication which is **essential** and use small properly labeled containers whenever possible.
   - **Prescriptive medications** must have a correct pharmacy label (ask your pharmacist for additional containers if needed).
   - **Over the counter medications** must be in the original, unopened container labeled with the student's name. (*No* loose medications/tablets in baggies will be accepted).
   - Sending **nutritional supplements** to camp is strongly discouraged, as these items will also need to be accompanied by physician's orders.
   - All **medication** labeling must **match** (dosage, time, tabs or liquid, etc.) what is written on the accompanying Medication Authorization Form.

Thank you for your assistance in making the camp experience safe and fun for your child!

Feel free to contact your school nurse with related questions or concerns.
Sue Henrikson, RNC / henriksons@riverview.wednet.edu / 425.844.4698

Highline School District #401 Medication Authorization Form

Student Name: _____ Birth Date: _____ Sex: __

School: _____ Teacher: _____ Grade: ___

HEALTH CARE PROVIDER completes this section: (please print)

I have determined that the medication named below is necessary during the school day or while the student attends overnight outdoor school and field trips sponsored by the district:

Diagnosis or reason for medication: _____

Name and Strength of medication: Name: _____ Dose: _____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other _____

If medicine is taken DAILY, specify time: _____

If medicine is to be given WHEN NEEDED, describe indications: _____

_____

How soon can it be repeated? _____

Length of time this treatment is recommended: ☐ This School Year (includes summer) ☐ Other: _____

Significant side effects: _____

All Grades: Asthma/Anaphylaxis Meds. Self Carry Approval (requires School Nurse Approval):

Is child allowed to carry and self-administer "**asthma/anaphylaxis meds**"? _____ Yes (MD/initials) _____ No (MD/initials)

If **yes**, I have trained this student in the purpose and appropriate method and frequency of use. _____ Initials

Grades 7-12 only: for medications that are *not* controlled substances: (requires School Nurse Approval):

Is child allowed to carry and self-administer this medication? _____ Yes (MD/initials) _____ No (MD/initials)

If **yes**, I have trained this student in the purpose and appropriate method and frequency of use. _____ Initials

Date: _____ Health Care Provider Signature: _____

Phone #: _____ Print Name: _____

Fax #: _____ Address: _____

PARENT/GUARDIAN completes this section:

I request that my child be allowed to take the medication as described above, I understand that is pending school nurse approval.
I request that authorized school staff assist my child in taking the medication(s) described above.
I understand that school staff will attempt to administer medication in a timely manner.
I will provide the medication in the original, properly labeled container.
I give my permission for the exchange of information between the school staff and health care provider.
I understand that my signature indicates my understanding that the school staff shall not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and in accordance with the District Policy and Procedure.

_____ (Date) _____ (Parent/Guardian Signature) _____ (Daytime Phone) _____ (Emergency Phone)

School Nurse Approval: _____ **(signature)** **Date**_____

School Nurse Fax # _____

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