Week ____ **KRAXBERGER CAMPER OUTDOOR SCHOOL**

HEALTH HISTORY FORM

Homeroom _____ BEST PHONE # _____

Camper's Name_____ Age_____ Gender _____

Mother's Name_____ Work Phone _____Cell #_____

Father's Name _____Work Phone _____Cell #_____

Family Doctor_____Phone_____

List two relatives or family friends we may contact if parents cannot be reached:

1._____ Relationship _____ Phone _____

2._____ Relationship _____ Phone _____

MEDICATIONS

STUDENTS REQUIRING MEDICATION: ORS 475.005-285

All medication given to students shall be dispensed strictly under the following:

A. Have sufficient medicine for the week. Medicine must be in original container with label indicating child's name, prescription number, date, dosage and what the medicine is.

B. With non prescription drugs, please send them with original bottle and label. Parent signature and instructions must accompany.

C. Medication must be administered by the ODS nurse.

Please list what you will be sending to camp for the week:

GENERAL HEALTH CONDITIONS

Please list any health conditions that might require special planning or consideration for this child's participation in Outdoor School activities, *i.e. bee sting allergy, bedwetting, heart problems, allergies, etc.*

Please list any and all known medical problems that we may encounter:

- Physical/Mental conditions: _____
- Allergies: _____
- Dietary Needs: _____

  **The camp can provide vegan, vegetarian, lactose-free, or gluten-free meals if arranged ahead of time.*
- Other: _____

IN CASE OF EMERGENCY, I hereby give permission to the physician selected by the school to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for my child, as named above. Parents will be contacted first whenever possible.

Parent or Guardian signature_____Date_____

Any directions to the contrary should be attached to this form when returned and signed by the parent or guardian

At times, it may become necessary to treat minor ailments by our ODS camp nurse. We have a limited supply of the following over the counter (OTC) medications for occasional use. These may be brand names or generic equivalents. The over the counter medications will be administered by label instructions based on your child's age and/or weight.

Please mark whether these medications are acceptable to give to your child (Yes/No).

Over the counter medications that will be available at camp	**Yes**	**No**	**Comments**
Advil (Ibuprofen) (headache, pain, etc.)			
Tylenol Caps or Children's Tylenol Liquid (headache, pain, etc.)			
Benadryl Caps or Children's Benadryl Liquid (allergy, sleep)			
Benadryl Spray (bug bites, rash)			
Hydrocortisone cream (bug bites, rash)			
Tinactin foot spray or cream (foot itch or burning)			
Triple Antibiotic ointment or Neosporin (minor cuts or scrapes)			
Lanacaine Spray (minor cuts or scrapes))			
Aloe Vera gel (minor sunburn)			
Muscle topical analgesic rub (muscle aches)			
Gas X (stomach aches and nervous stomach)			
Tums/Rolaids/Maalox (antacid)			
Cough drops			
Throat lozenges/spray (sore throat)			
Cough syrup - guaifenesin (expectorant)			
Cough syrup - DM formula (suppressant)			
Ora Jel (teeth, gum, mouth discomfort)			
Artificial Tears (eye irritations)			
Immodium (anti diarrhea)			

**If your child routinely uses any of the items listed above, please send it with them *in the original bottle* with label, written instructions, and parent signature. Give medications to nurse at time of departure.

I authorize the ODS camp nurse to administer any of the above medications indicated "**yes**" according to the medication label dose instructions for the child's age and/or weight, or as documented by above comments, as necessary for minor ailments.

Parent/Guardian Signature _____ Date _____