Palmyra Middle School - Outdoor Education Health
Information and Permission Form
CAMP WEEK PLEASE CIRCLE: Mountain Stream

Due Date: 2/6/19

Student name____________________________________Birth Date ____________________

Address ____

Student lives with ____

Father's name ____
Home phone number_________________ cell phone # ______________________
Father's place of business__________________ work phone #______________________
Email address ________________________

Mother's name ____
Home phone number_________________ cell phone # ____________________
Mother's place of business___________________work phone # __________________________
Email address __________________________

If we cannot be reached, please call: ____
Home phone number_____________________work phone # __________________________
Cell phone # ___________________
Family physician_________________________phone number __________________________

<u>General student health information</u>

1. Does your child wet the bed at night? ____

2. List any factors that may affect the care of your child while at Camp Swatara. Examples: epilepsy, diabetes, asthma, etc. ____
____

3. Does your child take any ***<u>prescription/nonprescription</u>*** medications? ____________________
If yes, please complete a blue medication form concerning the administration of each medication. **Each medication must have its' own blue form.** Extra forms are available from your teacher or Mrs. Waiter**.** **(***Medications must be in the original prescription bottle or over the counter package with your child's name and dosage clearly marked on it*). ***<u>Any nonprescription/over the counter medication must also have a doctor's order attached to a blue medication form including - name of student, medication, and dosage marked on it.</u>*** Please pack each medication with its own blue form in a zip-lock bag. If your child will have more than one medication please put all individual bags in one big zip-lock bag with your child's name on it. **Students will bring all medication with them on the Monday morning of their camp week to homeroom where it will be collected by the school nurse.**

-Continued on back-

4. Please note any **allergies to medications, food** (i.e. peanut butter, food dyes, lactose intolerance, vegetarian, etc.), **insects** (including bees) and **plants**. If your child is allergic to bee stings, please send the correct medications ordered by your doctor.

____
____

5. May the camp nurse administer standing order medications per the school physician? ________________

6. In case of an emergency, may we have your permission to call a doctor and have him/her attend, treat, and give medication by mouth or injection if needed? ______________________

7. Does your child wear contact lenses? __________________

8. Does your child wear an orthodontic brace or appliance?________________________

9. Additional health related comments:

____
____

With the above information, I also give permission for my child to participate in the resident Outdoor Education program at Camp Swatara in May.

Signature of parent or guardian ____________________________________
Date________________

If you have any health related questions please call (838-1331) or email the school nurse, Mrs. Stroup at amanda_stroup@pasd.us or Mrs. Waiter at michelle_waiter@pasd.us.

Please return this confidential form to your child's morning homeroom teacher by the date requested (2/6/19). Thank you.

Nurse's notes only

____
____
____
____