

Ohio FFA Camp Muskingum Medication Instructions

Please Note: *Due to regulations governing the administration of medication, Ohio FFA Camp Muskingum will adhere to the following policy. Please realize that this policy is enforced for the safety of your child and the protection of our staff.*

Parents: The Nature's Classroom Health Form should be filled out with the name of the medication, dosage, and times usually taken. If the child is prescribed medication after the health form has been turned in, please be sure to include a signed note, with the medication, with the above information included.

Unless medication is in the original container, it will not be given:

The original container is the box or prescription bottle in which it was purchased. This also includes non-prescription or over-the-counter medicine. Medicine lying loose in sandwich bags or other containers will **NOT** be given, even if the parent writes the name of the medication on the container. The only exception is single dose sealed medication with the product name on each individual dosage.

Please, **DO NOT** put several different medicines in one container. Each different medication must have its own container in order to be administered.

School Nurse: If medications are to come from the school nurse, please send the original containers with the child's name, dosage, amount, and times to be taken. Plastic bags, or containers with loose medications and only the child's first and/or last name are not acceptable, and **WILL NOT** be given.

Thank you for your cooperation!

Ohio FFA Camp Muskingum
Nature's Classroom
Students Health and Registration Form
Please thoroughly read and complete **BOTH** sides of this form

General Information

Name _____ Home Chapter _____

Age _____ Sex _____ Weight _____ Height _____ Date of Birth ____/____/____

Address _____
(Street) (City) (State) (Zip)

Mother's Name or Legal Guardian _____ Home # _____ Work # _____

Father's Name or Legal Guardian _____ Home # _____ Work # _____

Family Doctor _____ Doctor's # _____

If parents are not available in case of an emergency, notify: _____ Phone Number _____

Insurance Information

Is this person covered by family health insurance plan? Yes___ No___

What are the Last Four Digits of the Student's Social Security Number _____

If covered, what is the insurance company? _____

Name of person who is the prime insured holder: _____

Please write the insurance I.D. number (It is on your Insurance Card) _____

I give permission for (student's name) _____ to attend Nature's Classroom for the period of (dates of program) _____ as part of the outdoor education of (school) _____ and to be subject to the authority of the program director. I give permission for the above to participate in any planned activities under the supervision of the director or assigned staff member. I also understand that the director or school leaders may dismiss my child from the encampment if, in their opinion, his/her conduct or influence is not in the best interest of the entire group. I will not hold Nature's Classroom, FFA Camp Muskingum, or the aforementioned school responsible or liable for accidents which may occur to the camper while on the camp premises, or for loss of personal articles brought to the Nature's Classroom Program. I also give permission for use of any photo of the above named to be used for program public relations.

I understand that my child's participation in programs offered by FFA Camp Muskingum including the adventure activities and living history reenactments are based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential hands on teaching techniques, and that my child's participation is purely voluntary.

I hereby give permission for emergency treatment of my child in case of accident or illness, and for normal treatment during the program. I realize that FFA Camp Muskingum will make every effort to contact, first the *legal guardians*, followed by the person to notify in case of emergency. If neither one can be reached, I hereby give permission to the medical personnel selected by the program director and/or assigned staff member to order routine tests, X-rays, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation. I also give permission to the physician selected by the program director and/or assigned member to secure and administer treatment, including hospitalization, for the person named above.

Non-Prescription Medication: Should my child become ill, get a headache, catch a cold, or have other minor medical or dental problems, I give permission for the administration of non-prescription medication in accordance with the camp's medical treatment procedures? **(PLEASE MARK ONE)** Yes___ No___

If needed, Tylenol will be administered, unless otherwise specified: Other (specify) _____

I understand that by signing below I have read and understand the above statements.

Signature Relationship Date

Health Information **This health form must be filled out completely and thoroughly**

Dear Parents:

If your child must take any medication, carefully read the medication instructions below. Medication WILL NOT be administered unless all of the instructions are properly followed. It is necessary that the school and camp authorities know your child's physical and mental condition. If you have any doubt that your child is in good health, have a physician examine your child and forward the report to the camp.

1. Medication

- a. If your child must take any medication, send medicine in the ORIGINAL CONTAINER.
- b. PRESCRIPTION MEDICATIONS must be accompanied by a pharmacy label containing the RX number, the name of the medication, and dosage, directions for administration, and the child's name.
- c. NON-PRESCRIPTION MEDICATIONS must be in their original containers, clearly labeled with the child's name, name of the medication, and directions for its use.
- d. Medicine lying loose in sandwich bags or other containers will not be administered.
- e. Your child will not be allowed to keep any medications in the dormitory.

Please complete the following areas that pertain to the student.

Please check the appropriate Box:	<input type="checkbox"/>	This Person takes NO medication on a routine basis.
	<input type="checkbox"/>	This person takes medication as follows:

Medication	Reason (optional)	Dosage	√ if prescribed by Doctor	Administering Directions	√ if Taken with Food	Due to program scheduling, medications are administered during meal times. Please circle approximate times meds are taken.
						7:30am 12:00pm 5:30pm 10:30pm Other ____ am/pm
						7:30am 12:00pm 5:30pm 10:30pm Other ____ am/pm
						7:30am 12:00pm 5:30pm 10:30pm Other ____ am/pm

Please Look Over and Follow the Medication Instructions Above

I hereby give permission to the program director, assigned staff member, and/or school personnel to help self administer medication to the student stated on this form.

_____ Signature	_____ Relationship	_____ Date
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2. Allergies (food, insect bites, drugs, others): _____
3. Has your child been exposed to any communicable disease within the past 10 days? If yes, what disease _____
4. Are there any physical activities in which your child should not participate? _____
5. Has your child ever had a problem with homesickness? If YES, please explain briefly? _____
6. Date of last tetanus shot, if known: _____
7. Is your child up to date on all immunizations required for school? _____
8. Any other information we need to know about your child (special health concerns, special diet, recent hospitalizations, fractured bones, etc.): _____

Please feel free to attach an additional form if your child takes additional medication or there is anything else you think we need to know.