High Trails Outdoor Science School

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RUNNING PROGRAM IN THE
SAN BERNARDINO NATIONAL FOREST
WWW.DIRTYCLASSROOM.COM

LEARNING HOW WE CAN ALL FIT TOGETHER ON ONE HEALTHY PLANET

Medication Form *Use this form only if you are sending meds up with your student.*

STEP 1: STUDENT INFORMATION

Student Name:	**Doctor's Name:**
Birthdate:	**Doctor's Phone Number:**
School Name:	**Doctor's Stamp OR Address:**
Parent/Guardian Name:	
Relationship:	
Contact Number:	

STEP 2: MEDICATION INFORMATION

PLEASE *Do not send up common medications like Tylenol, cough drops, etc. UNLESS it is taken on a daily basis.*
We have most common Over The Counter Medications available and will administer them to your child if they ask for it or need it.

MEDICATION All medication, including over the counter medications and vitamins, must be in the original package/box/bottle and NOT EXPIRED.	***DOSAGE*** How much do we administer? High Trails will supervise but cannot administer injections.	***SCHEDULE*** Early: 6:30 am	Breakfast: 8am	Lunch: 1pm	Dinner: 6pm	Bedtime: 9pm	Give As Needed	***REASON FOR MEDICATION and POSSIBLE REACTIONS NOTES*** Please give us any needed background on the medication or potential reactions that may occur.	***Expiration Date: MM/YY***	***CHOOSE ONE FOR EACH MEDICATION:*** Over the Counter OTC: Medication that you can buy without a prescription. It must be **age appropriate** and all labels must be in English.	OR	***RX*** Prescription Labels Must Match This Form and State: Patient, Physician, Medication, Dosage, Frequency&Exp Date. **Your Doctor must sign for each RX medication below or we cannot administer***
EXAMPLE: Amoxicillin	1 pill 3 times a day		X	X	X			- Ear Infection - May cause sleepiness	12/18	☐	OR	*Dr. Brown* Dr. Signature Here
EXAMPLE: Vitamin C	1 pill once a day		X					None	3/19	☑	OR	-------
1.										☐	OR	Dr. Signature Here
2.										☐	OR	Dr. Signature Here
3.										☐	OR	Dr. Signature Here
4.										☐	OR	Dr. Signature Here

Dr's Signature box may be left blank and unsigned if you attach to this form a signed doctor's permission for your RX medication. This permission must match the medication label and state: 1) Patient Name, 2) Physicians Name and Contact Information, 3) Medication,4)Dosage, 5) Frequency, and 6)Physician Signature.

STEP 3: PARENT/GUARDIAN PLEASE READ AND SIGN BELOW:

I, the undersigned, who is the parent/guardian of the student named above, request the administration to my child of both the over the counter medicine and the prescribed medication in accordance with the instructions as indicated above. **I recognize that if I do not correctly follow all of the steps and fulfill all of the instructions above that I will be contacted and medication will be withheld until this form has been completed.** If I do not correct this form expediently, I understand that I may be asked to pickup my child from program. I understand that High Trails, Incorporated is not legally obligated to administer medication to my child, and therefore, I agree to hold High Trails, its employees, the school district, and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them. I will notify the school immediately if any medical or contact information changes.

PARENT/GUARDIANSIGNATURE:_____**DATE:** _____

Please put Medication and Form in a Clear Ziplock Bag and give it to your Teacher. No Meds in Student Luggage!