Teacher: Carrington A. Light **Group/Activity**: 8th Grade Ashland Field Study

Days Attending: May 27-29, 2025

STUDENT HEALTH HISTORY FORM FOR FIELD STUDIES AND COMPANION PROGRAMS (Please Print)

Confidential, for RIVERDALE GRADE School Nurse, Field Studies Coordinator and Site Supervisor/Teacher use only. To be archived and destroyed by RGS. **THIS FORM IS DUE TO THE FRONT OFFICE NO LATER THAN MAY 20, 2025.**

In order for your child to attend Field Studies, *all information* on this form must be completed. If your child's condition changes after you submit this form, please send a note to the Field Studies Coordinator and School nurse.

Student's Full Name _____Birth Date_____ Age_____ Gender _____

Parent/Caregiver's Name _____

Cell Phone _____ Alternate Phone(home/work) _____

Parent/Caregiver's Name _____

Cell Phone _____ Alternate Phone(home/work) _____

Student's Address_____ City _____ Zip _____

Emergency Contact #1 _____ Relationship_____ Phone_____

Emergency Contact #2 _____ Relationship_____ Phone_____

	ALLERGIES (*please list on the back of this page)		Mobility Issues
	Asthma or other breathing conditions		Physical Injuries (recent)
	Bowel / Bladder Condition		Seizure Condition
	Bedwetting		Skin Condition
	Diabetes		Sleep Walking
	Emotional/behavioral or learning concerns		Vision Condition
	Hay Fever		Heart Condition
	Hearing Condition		Other chronic or recent illnesses:
	Recent surgical procedures (specify):		

*Please provide more specific information about identified health concern including treatment needed while at Field Studies:

_____

_____

Are there any activity restrictions i.e. strenuous hiking, tug-of-war, etc? _____

_____

Special dietary needs (examples: vegetarian, vegan, gluten-free, Halal, Kosher) etc: _____

_____

FOOD ALLERGIES: Please list food allergies here, and contact our office if you have specific questions:

_____

_____

MEDICATION ALLERGIES: _____

_____

MENTAL HEALTH CRISIS: **Legal parents/caregivers are contacted first whenever possible.**

Is your student currently receiving mental health services? _____ If yes, who is the Provider? Name _____

Phone Number _____ May we contact them in a mental health emergency? _____

Other pertinent health information or safety concerns: _____

_____

Other needs we should know about (privacy needs, anxiety/nervousness, etc.):_____

_____

In case of medical or surgical emergency, I hereby give permission to the Field Studies Coordinator and or Site Supervisor to arrange transport for my child, as named above, to the hospital for evaluation by a Healthcare Provider.

Legal Parent's or Caregiver's Signature: _____ Date_____

Child's Insurance Information_____

IF YOUR CHILD WILL NEED MEDICATION WHILE AT FIELD STUDY, PLEASE READ AND COMPLETE THE INFORMATION BELOW AND ON PAGE 4.

Field Study Teachers do not supply over-the-counter medicine; it needs to be brought from home.

MEDICATION RULES

1. All medication must be maintained and administered by the Field Studies Coordinator or Site Supervisor. Medications include prescription, over-the-counter, and vitamins/supplements. Students are not allowed to carry their own medication or supplements. **Some exceptions are made for emergency asthma inhalers and auto-injectors for severe allergic reactions.**

2. Any prescription, over-the-counter medication, or vitamin/supplement must have the following:
   - ✦**Parent/Caregiver must sign the authorization on page 4.**
   - ✦ Parent/Caregiver must include the following:
     - **Name** of medication
     - **Dose** (strength and how much) of medication
     - **Time and Dates** medication should be given
     - **Purpose** or reason for medication
   - ✦ All medication must be in the original container (prescription, over-the-counter, and vitamins/supplements). **No medication will be accepted or given if they are sent to Field Study in unapproved containers (i.e., envelopes, baggies, pill planners etc.)**
   - ✦ Prescription medication must have an accurate label. **This includes samples given by healthcare providers. If the directions on the prescription label are different from what the healthcare provider is currently prescribing, written instruction is required from the healthcare provider. This also includes directions for over-the-counter medications.** See "Health Care Provider Directions" on the next page.
   - ✦ **All inhalers must be appropriately labeled with their prescription.**

   - ✦ **Sign here if you would like your child to carry and self-administer their emergency asthma inhaler and/or auto-injector.** _____
     (parent/caregiver signature)

Name of the emergency inhaler and/or auto-injector and directions: _____

_____

_____

Your child must be developmentally and behaviorally able to carry and self-administer their inhaler and/or auto-injector.

3. **All vitamins/supplements require a note from your health care provider in order to give, see OAR 581-021-0037.**

   The note needs to include the name of the student, name of vitamin/supplement, dose, time, purpose, and a signature from their health care provider including the date signed**. (Examples are: melatonin, Lactaid, probiotics, daily vitamins, herbs, homeopathic supplements, and enzymes.)**

   Over-the-counter medicine is not the same as vitamins/supplements. Over-the-counter medicine is approved by the FDA. Vitamins/supplements are not FDA approved and cannot be given without a note from the Health Care Provider.

TEACHER: Carrington A. Light STUDENT'S FULL NAME_____

PARENT/CAREGIVER AUTHORIZATION FOR FIELD STUDIES COORDINATOR OR SITE SUPERVISOR TO ADMINISTER MEDICATIONS. (Prescription, Over-the-Counter, Vitamins/Supplements)

I am requesting that my child, _____, be given or be assisted in taking:

Name Of Medication	Dosage (amount)	Time(s) To Be Given If once daily, specify am or pm.	Dates To Be Given	Purpose Of Medication

Parent /Caregiver Signature _____ Date:_____

This authorization applies only to the medication listed above and for the duration of treatment or week. This also authorizes an exchange of information, as necessary, between the nurse, appropriate school personnel, my child's health provider, and/or my child's pharmacist.

HEALTHCARE PROVIDER (HCP) DIRECTION

(Required in writing IF the prescription label does not match the parent's/caregiver's direction above)

Special instructions including adverse reactions and action required:_____

_____

_____ _____ _____

HCP's Name (print or stamp) **HCP's Signature** **Date**

_____ _____

Address **Phone #**

THIS PAGE FOR FIELD STUDIES COORDINATOR OR SITE SUPERVISOR ONLY

RECORD OF MEDICATIONS
(For School Use Only)

STUDENT NAME:_____

FIELD PROGRAM:_____

DATES ATTENDING_____

TO BE ADMINISTERED BY THE SITE SUPERVISORS:

Initials	Signature	Initials	Signature

Use the following key for days medication not given: X = Not at site **0** = Student refuses/parent/caregiver notified **NS** = No Show
(Please: use **one line only per dose** administered) (initial each entry)

Count In/# Initial	Count Out/# Initial	Medication Name and Dose	Time	Date	Date	Date	Date	Date	Date

Medication Record (As needed medications.)

(Please: use **one line only per dose** administered)

Date	Time	Medication, route, dosage, reason	Initials