

School \_\_\_\_\_

**McDowell Environmental Center**  
**STUDENT HEALTH FORM**  
(All information is confidential-PLEASE PRINT)

STUDENT NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (PREFERRED NAME)

**STUDENT INFORMATION:** Date of Birth: \_\_\_\_\_ Sex: M / F Age \_\_\_\_\_ Grade: \_\_\_\_\_

Primary Physician \_\_\_\_\_ Physician Phone \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_

**CONTACT INFORMATION:** Address \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIPCODE)

Phone \_\_\_\_\_  
**INCLUDE AREA CODE** Primary Number (ex. Home) Secondary Phone Number (ex. Cell) Alternate Phone Number (ex. Work)

EMERGENCY CONTACT: \_\_\_\_\_  
(NAME & Relationship to Student) (Day Phone) (Evening Phone)

**STUDENT HEALTH INFORMATION:** Height & Weight: \_\_\_\_\_ Tetanus \_\_\_\_\_ Contacts? Yes / No  
(YEAR)

**ALLERGY INFORMATION**  
**(USE ADDITIONAL SHEETS IF NECESSARY)**

To the best of your knowledge does your child have any allergies? YES / NO (Circle correct response)

If YES was circled please indicate to which of the following your child is allergic. Please be specific:

INSECTS: \_\_\_\_\_

FOODS: \_\_\_\_\_

PLANTS: \_\_\_\_\_

ANIMALS: \_\_\_\_\_

OTHER: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

Please indicate what treatment your child should receive if exposure occurs to any of the first five (Any medications to which your child is allergic will NOT be given): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*\* If your child is bringing an EPI-PEN to the Center you MUST talk with the nurse before your child arrives \*\***  
[CONTACT MEC NURSE at [RN4CMCD@HOTMAIL.COM](mailto:RN4CMCD@HOTMAIL.COM) or 205-387-1806]

**ADDITIONAL HEALTH CONCERNS**

Is student on a special diet? Y / N Please explain, (what they CAN eat as well as what they CANNOT eat): \_\_\_\_\_

\_\_\_\_\_

HEALTH PROBLEMS: \_\_\_\_\_

\_\_\_\_\_

PLEASE READ, COMPLETE and SIGN THE BACK SIDE [pg 2] OF THIS FORM

**RELEASES**

**PHOTO RELEASE**

"I give my permission for any photos or videos taken of my child or any artwork made by my child during educational programs at the Center to be used for the public relations of the program."

**ACCIDENT INSURANCE COVERAGE**

Accident insurance costs are covered in the program fee and protect all students throughout the program. The maximum benefits are: Sickness, \$1000; Accidents, \$2500; and Loss of Life, \$2500. Parents or guardians are responsible for expenses in excess of these amounts.

**REGARDING MEDICATIONS WHILE AT the CENTER**

**GENERAL RULES:**

- \*\*The Center follows rules similar to your child's school.
- \*\*All medications must be in their original container with the student's name and school written on the container.
- \*\*There must be clear directions on when &/or why to give the medication.
- NOTE: Give as directed is NOT acceptable**
- \*\*The container must specify the strength and dose of the medication.
- \*\*If it is an Over-The-Counter medication **it MUST be age-appropriate** and will be given following manufacturer recommendations. If it is not recommended for your child's age and your child's Health care provider prescribed it then a note from that provider must be sent with the OTC medication.

**PRESCRIPTION MEDICATIONS:** The follow section must be filled out by the student's PARENT or LEGAL GUARDIAN (ALL MEDICATION IS DISPENSED BY A LICENSED NURSE OR AUTHORIZED SCHOOL PERSONNEL)

List **ALL PRESCRIPTION MEDICATIONS** you plan to send with your child and the reason(s) your child takes them. (Attach Additional Sheet if Necessary)

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time Given \_\_\_\_\_ Reason \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time Given \_\_\_\_\_ Reason \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time Given \_\_\_\_\_ Reason \_\_\_\_\_

**OVER THE COUNTER (OTC) MEDICATIONS:**

**\*\* ALL OTC MEDICATIONS MUST BE PROVIDED BY PARENTS/LEGAL GUARDIANS OF THE STUDENT \*\***

Please list below the medications you plan to send for your child and the reason(s) why your child should take them. (Attach Additional Sheet if Necessary)

**Name of OTC Medication**

TYLENOL  
(EXAMPLE)

**Reason(s) for Giving**

GIVE ACCORDING TO MANUFACTURER RECOMMENDATIONS  
(EXAMPLE)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

"I AUTHORIZE THE MEC NURSE, OR AUTHORIZED SCHOOL PERSONNEL, THE TASK OF ASSISTING MY CHILD IN TAKING THE ABOVE MEDICATIONS."

"I GIVE THE MEC NURSE PERMISSION TO SPEAK WITH MY CHILD'S HEALTH CARE PROVIDER OR PHARMACIST AND AUTHORIZE MY CHILD'S HEALTH CARE PROVIDER OR PHARMACIST TO SPEAK WITH THE MEC NURSE SHOULD A QUESTION COME UP ABOUT ONE OF MY CHILD'S MEDICATIONS".

ALL HEALTH INFORMATION IS CONSIDERED CONFIDENTIAL AND WILL BE SHARED ONLY ON A NEED-TO-KNOW BASIS TO ENSURE THE SAFETY OF YOUR CHILD.

**"This is to certify that the information provided on this form is accurate to the best of my knowledge,"**

\_\_\_\_\_  
SIGNATURE OF PARENT or LEGALGUARDIAN

\_\_\_\_\_  
DATE

EFFECTIVE DATES ( Dates of Trip): \_\_\_\_\_

Student Name: \_\_\_\_\_