

FORT ZUMWALT SCHOOL DISTRICT

DISTRICT ADMINISTRATIVE OFFICES

110 Virgil Street
O'Fallon, Missouri 63366

Telephone: (636) 272-6620
Metro: (636) 240-2072
Fax: (636) 272-1816
Web Site: www.fzschoools.org

Dr. Bernard J. DuBray
Superintendent of Schools

Jackie Floyd
Assistant Superintendent
Curriculum and Instruction

HEALTH INFORMATION SHEET

Information furnished by you on this form is necessary for us to provide the best conditions of caring for your child.

STUDENT NAME _____ HOME ROOM TEACHER _____
FIRST LAST

PARENT/GUARDIAN _____ HOME PHONE _____
FATHER/MOTHER (FIRST & LAST)

ADDRESS _____ DAY PHONE _____

PARENT EMPLOYER
NAME & ADDRESS _____

FATHER EMPLOYER ADDRESS PHONE

MOTHER EMPLOYER ADDRESS PHONE

PHYSICIAN _____
NAME ADDRESS PHONE

Check any conditions pertaining to your child. Explain below type of reaction, medication used, or special instructions.

___ Allergies (to include bee stings, bug bites)

___ Asthma

___ Diabetes

___ Seizure Disorder

___ Heart Conditions

___ Orthopedic Conditions

___ Attention Deficit Disorder

___ Fears/Anxieties

___ Never experienced A Night Away

___ Sleep Walker

___ Enuresis (bed wetting)

___ Food Allergies

___ Other Health or Physical Needs

___ Last DPT/DT or Tetanus (Date _____)

Explanations _____

If your child will be taking medicine at camp, we must have a medicine information form turned in before we leave for camp. This form will be distributed to all parents before we go to camp. All medicine to be taken at camp must be checked in to the nurse. Be sure it is clearly labeled and that the instructions are specific. Please complete and return immediately.

I hereby authorize the nurse or any member of the administration and/or outdoor education staff to transport my child to the hospital, and to hospitalize him/her for an emergency. Furthermore, I hereby authorize the physician(s) to carry out any diagnostic procedure or emergency care, pertinent to the immediate illness that is deemed imperative in the treatment of my child. Parents will be notified in case of emergency.

Signature of Parent/Guardian _____ Date _____

THIS FORM MUST BE RETURNED BEFORE CAMP & PARENTS MUST SIGN BOTH SIDES-OVER

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Dear Parents:

During the course of your child's camp stay we often find it advisable to use ingested or topical medications in the treatment of minor injuries or illnesses. A few such conditions are sore throats, cough, headaches, stomach aches, scratches, blisters, etc.

The products that we use most often during the camp stay are listed below. If you do not want your child to receive the benefit of any product listed below, please cross out that particular medicine:

Anti-diarrheal
Benadryl
Cough Syrup
First Aid Spray
Hydrogen Peroxide
Ibuprofen
Kill-Sting Swabs (for insect stings)
Mylanta
Maalox
Midol
Milk of Magnesia
Rubbing Alcohol
Sterile Eye Wash
Sudafed
Throat Lozenges
Tums
Tylenol
Vaseline

NOTE: THE MEDICATIONS LISTED ABOVE ARE PROVIDED BY THE CAMP NURSING STAFF AND ARE NOT TO BE SENT WITH YOUR CHILD.

Sincerely,

Camp Nursing Staff

I hereby give my permission for my child, _____, to receive any of the ingested or topical medications listed above, EXCEPT THOSE CROSSED OUT during his/her stay.

Signature of parent or guardian _____ Date _____

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PARENT PERMISSION FOR MEDICATION AT CAMP

This form is required only for students needing medication not listed on the back of the Health Information Sheet. Parents of students requiring "daily medication" or "occasional medication" must complete the following information for each medication. The medication must be well-labeled. **IT IS THE RESPONSIBILITY OF THE STUDENT TO TAKE THE MEDICATION AT THE APPROPRIATE TIME.** Please go over this sheet with your student.

Name of Student _____ Teacher _____

Condition _____

Medication _____

Dosage _____

Side Effects _____

Check Times to be Taken:

___ Breakfast

___ Lunch

___ Afternoon

___ Dinner

___ Bedtime

___ Only as Needed

Condition _____

Medication _____

Dosage _____

Side Effects _____

Check Times to be Taken:

___ Breakfast

___ Lunch

___ Afternoon

___ Dinner

___ Bedtime

___ Only as Needed

Condition _____

Medication _____

Dosage _____

Side Effects _____

Check Times to be Taken:

___ Breakfast

___ Lunch

___ Afternoon

___ Dinner

___ Bedtime

___ Only as Needed

Condition _____

Medication _____

Dosage _____

Side Effects _____

Check Times to be Taken:

___ Breakfast

___ Lunch

___ Afternoon

___ Dinner

___ Bedtime

___ Only as Needed

Comments:

Parent Signature _____ Date _____