



High Trails Outdoor Science School

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

Understanding How We Can All Fit Together On One Healthy Planet

Medication Form

STEP 1: STUDENT INFORMATION

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

STEP 2: MEDICATION INFORMATION

Medication	Dosage	Schedule					Reason for Medication Possible Reactions Notes	CHOOSE ONE FOR EACH MEDICATION:		
		Early: 6am	Breakfast: 8am	Lunch: 1pm	Dinner: 6pm	Bedtime: 9pm		Over the Counter	OR	RX Prescription
All medication, including over the counter medications and vitamins, must be in the original package/box/bottle.	How much do we administer? High Trails will supervise but cannot administer injections.						Please give us any needed background on the medication or potential reactions that may occur.	OTC: Medication that you can buy without a prescription. It must be age appropriate and all labels must be in English.		Labels Must State: Patient, Physician, Medication, Dosage, and Frequency. <u>Your Doctor must sign on line below or we cannot administer!</u>
EXAMPLE: Amoxicillin	1 pill 3 times a day	X	X	X			May cause sleepiness	<input type="checkbox"/>	OR	<i>Dr.'s Signature</i>
EXAMPLE: Vitamin C	1 pill once a day	X					None	<input checked="" type="checkbox"/>	OR	-----
1.								<input type="checkbox"/>	OR	
2.								<input type="checkbox"/>	OR	
3.								<input type="checkbox"/>	OR	
4.								<input type="checkbox"/>	OR	
5.								<input type="checkbox"/>	OR	

PLEASE!! Do not send up common medications like Tylenol, cough drops, etc. for your child unless they take this 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.

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/Guardian Signature: _____ Date: _____

Please put Medication and Form in a Clear Ziplock Bag and give it to your Teacher.