Return Completed Forms to: Bright Lights, Inc. 5561 S 48<sup>th</sup> St., Suite 220 Lincoln, NE 68516



## STUDENT MEDICAL INFORMATION FORM

- This form is only needed if you indicated a medical condition requiring administration of an inhaler, EpiPen, insulin,
  or other daily prescribed medication while your student is at Bright Lights so that we may coordinate appropriate
  care.
- If you have questions about this form, please contact our office at 402-420-1115. A nurse will be on site at Roper Elementary School during Bright Lights summer camp weeks 1, 4 & 5.
- A request to provide medication will only be administered at Roper Elementary School during Bright Lights summer camp weeks 1, 4 & 5. A physician's authorization is required for medication to be provided. The prescriber's authorization may be on the pharmacy label attached to the medication. Send original container with label intact. Home packaging will not be accepted due to safety considerations.

	Age:		
Bright Lights Camp(s), Dates and Times Attending:			
Address:			
This student uses the following emergency or daily medication Inhaler EpiPen Insulin			
List Allergies:			
List current daily medications and dosage:			
Parent/Guardian Name:	Phone:	cell/work/home?	
Address (if different than student):			
Student's Physician:	Phone:		
1) Asthma: Activity Induced?	Diabetes: At what times/intervals does your student check		
Yes No	blood sugar?		
2) Additional medical information/concerns:			

I give permission to Bright Lights to provide		(name of medication and dose)
to	(child's name) at	(approximate time) as
directed for	(reason for medication).	
Signature of parent or guardian	 Date	
Student Self-Administration of Medi Bright Lights encourages pro-active, self-manag administration if 6 <sup>th</sup> grade and above. If an EpiP health office at Roper Elementary. Parent/legal end of each week.	<b>cation:</b> Tement of health conditions by stude en is administered, 911 will be calle	d. All medication will be kept in the
Please check which of the following situations a	applies to your student and sign belo	ow:
1) My student is in 6 <sup>th</sup> grade or above and is Form and return with Medical Information Form	-	mplete Student Self-Administration
Only students 6 <sup>th</sup> grade and above ma		
a) carry the: Inhaler EpiPen b) keep the: Inhaler EpiPen		
<ul> <li>2) My student is not capable of self-adminated Roper Elementary, not at any of our community.</li> <li>3) I will not be sending medication with my</li> </ul>	nity site camps. <i>You do not need to d</i>	complete Student Self-Administration
at Roper Elementary, not at any of our commun Form.	nity site camps. <i>You do not need to d</i>	complete Student Self-Administration

## **Student Self-Administration Permission Form**

If your student is self-administering and/or carrying an Inhaler, EpiPen, or Insulin/glucose, a parent/guardian and physician must complete this Statement of Authorization.

STATEMENT OF AUTHORIZATION					
has been instructed in the proper use of :  (Student's full name)					
Please check:	Inhaler	EpiPen	Insulin/Glucose		
I,(Parent/Legal G	uardian)	, request that	(Student's full name)	be permitted to carry:	
			Insulin/Glucose		
on their person or to keep same in their classroom, as we consider them responsible. Student has been instructed in and understands the purpose and appropriate method and frequency of use of their Inhaler, EpiPen or diabetic equipment.  Medication may be self-managed. I am affirming my confidence that my student has the knowledge and skills needed to self-manage. We, student and parent (under the advisement of my student's physician) have developed a plan for self-provision of the medicine, storage of medicine, and a plan for reporting that is deemed safe and appropriate. Student agrees to notify the Bright Lights staff immediately when experiencing any difficulty with his/her medical condition/health management.  I, the undersigned parent/guardian, absolve Bright Lights, Inc. and its employees, agents, representatives and officers of any responsibility in safeguarding my student's Inhaler, EpiPen or diabetic equipment. I accept ultimate responsibility for monitoring the					
I, the undersigned treating physician, agree with and become party to this Statement of Authorization:  x Date Physician's Signature (Required for authorization of student self-administered medication.)					
				re	
Parent/Legal Guardi	an Signature Rec	quired			

Return completed form, along with Medical Information, to: Bright Lights, 5561 S 48th Street, Suite 220, Lincoln, NE 68516