Complete & Return

ALL STUDENTS

STUDENT OVERNIGHT TRAVEL

Student Insurance Waiver Form / Permission to Treat

***Important* - This notification must be signed and returned before your student can participate in this travel.**

Student's Full Name: _____

Home Address: _____

Home Phone # _____ **Parent/Guardian Cell #** _____

Overnight Student Travel To: _____

STUDENT INSURANCE WAIVER

For overnight travel, student insurance must be taken unless this insurance waiver form is signed by the parent/guardian indicating adequate personal insurance. This waiver releases the Board of Education and its employees from responsibility for any claim due to injuries received while participating in a school-sponsored overnight travel.

1. Pursuant to Board Policy 4220 and the current Student Accident Coverage insurance I wish to proceed as follows: (Check one)

   a) ____ I have adequate personal insurance and release the Board of Education and its employees from any responsibility in this matter. My medical insurance information follows:

   Insurance Company _____ Policy #: _____

   Company Phone #: _____ Name of Insured: _____

   b) ____ My son/daughter is already enrolled in the current Student Accident Coverage insurance program. I understand I am responsible for payment of any charges not covered by this policy.

   c) ____ I need to purchase the current Student Accident Coverage insurance. I am enrolling my son/daughter online by going to http://www.knoxinsurance.com and following the enrollment instructions.

2. There are limitations in the Student Accident Insurance coverage. The responsibility to pay for any necessary medical treatment not covered by the Student Accident Insurance coverage or personal insurance coverage belongs to the family.

3. Neither the Board of Education nor any of its employees will assume responsibility for claims resulting from injury to your child while he or she is participating in this program.

PERMISSION TO TREAT

I give permission for my son/daughter, _____, to be treated in case of a medical emergency. I understand in the case of an emergency my child will be taken to the nearest medical treatment facility immediately and I will be contacted. In the case I am not able to be reached, I am providing the names of two emergency contacts.

1) Name: _____ Phone # _____

   Relationship: _____

2) Name: _____ Phone # _____

   Relationship: _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Overnight Fieldtrip Procedure for Medicines

Dear Parent(s)/Guardian,

Please follow the guidelines below for your child if he/she needs medicine during the overnight field trip. Please note the CCS medication policy is the same on any field trip, including overnight, as it is during regular school hours. If you have any questions or concerns, please contact your School Nurse.

1. **Any medicines that are currently kept in the School Nurse's office will be sent on the field trip to be given as ordered by the teacher. No additional paperwork is needed.**

2. **If your child normally takes medicine outside the school hours and will need to take it while on the field trip, please follow the guidelines below:**

Complete the next form in this packet

- **Prescription or over-the-counter medicine to be given by school staff** must have medicine order completed and signed by a medical provider. Parent must sign medicine order allowing school staff to give medicine. Medicine must be sent in a pharmacy bottle with prescription label or in the original container with your child's name and least amount needed. Medicine and order must be given to the School Nurse to review before the field trip.
- **Prescription medicine to be self- administered by the student** must have a medicine order completed and signed by a medical provider. Parent needs to sign medicine order allowing the student to self medicate. Student will need to meet with the School Nurse to complete self med contract before the field trip. Medicine must be sent in the original container with prescription label and least amount needed. Medicine order must be given to the School Nurse to review before the field trip.
- **Over the counter medicines to be self-administered by the student** must have a note from parent attached to medicine allowing the student to self medicate. Note must include medicine name, amount, time and parent signature. Medicine should be sent in its original container with student's name on it and least amount needed.

All medicine orders and/or medicines for the overnight field trip are due to the School Nurse to review by 4/14/2014 .
date

Thank-you for helping to make this a fun and safe trip for your child. Please call if you have any questions.

Pam Dunbar
School Nurse

704-782-0115
Phone

07/12

Cabarrus County Schools

*PRESCRIPTION ONLY!

Creating the Future KCS Kannapolis City Schools

Medication Authorization for Students

Student's Name: _____ **Birth Date:** _____

School Year: _____ **Grade:** _____

In order to keep this student in optimum health and to help maintain maximum school performance and sustain attendance, it is necessary that medication be given during school hours.

Name of Medication: _____

***Only one medication on each med auth form.**

Circle One: Tablet Capsule Liquid Inhaler Nebulizer* Patch Drops Injection* Rectal* Other: _____
*Please indicate physical condition for which specialized physical health care (nursing type) procedure is to be provided:

_____

Dosage (amount to be given) _____

Time/Frequency: _____A.M. _____ P.M. or As Needed every _____

Reason for Medication: _____

Side Effects (expected or predicable): _____

Termination Date: _____ (All medication orders expire at the end of the school year unless otherwise stated.)

Physician's Signature: _____ Date: _____

Physician's Name Printed: _____ Telephone #: _____

Parent Authorization: Please sign the authorization that applies to your child below.

Parent permission for medication to be administered by the school nurse/staff:

- I hereby give my permission for my child (named above) to receive medication during school
- hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.
  I will furnish all medication for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

Parent/Guardian Signature: _____Phone: _____ Date: _____

OR

Parent Permission for medication to be SELF-ADMINISTERED by their child (K-5 consult with School Nurse):

- I agree to the Medication authorization as written by the above medical provider.
- I hereby request that my child be allowed to carry and self-administer the medication at school as prescribed by my child's licensed health care provider. I understand my child must carry this medication at all times in school or he/she will lose the right to carry it. I further understand that the school undertakes no responsibility for the administration of the medication. I hereby release the School Board, its agents and employees, from any and all liability that may result from my child taking this medication. My child is knowledgeable about this medication and how to self-administer it.
- I agree to ensure that the medication will have a pharmacy label with my child's name.

Parent/Guardian Signature: _____Phone: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Cabarrus County Schools

Receta Medica solo!

Creating the Future KCS Kannapolis City Schools

Medication Authorization for Students

Student's Name: _____ **Birth Date:** _____

School Year: _____ **Grade:** _____

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*Please indicate physical condition for which specialized physical health care (nursing type) procedure is to be provided:

_____

Dosage (amount to be given) _____

Time/Frequency: _____A.M. _____ P.M. or As Needed every _____

Reason for Medication: _____

Side Effects (expected or predicable): _____

Termination Date: _____ (All medication orders expire at the end of the school year unless otherwise stated.)

Physician's Signature: _____ Date: _____

Physician's Name Printed: _____ Telephone #: _____

AUTORIZACION DE LOS PADRES: Por favor firme la autorización que se aplica a su hijo/a.

Autorización del padre para que el medicamento sea administrado por la enfermera /personal escolar:

- Por la presente, doy autorización para que mi hijo (nombrado arriba) reciba medicamento durante el horario escolar.
- Este medicamento ha sido recetado por un proveedor de salud licenciado. Por la presente libero a la Junta escolar, sus agentes y empleados, de cualquier y toda responsabilidad partir que pueda resultar a partir de que mi hijo/a tome el medicamento recetado. Este consentimiento es bueno por el año escolar, a menos que sea revocado. Proporcionaré todos los medicamentos para uso en la escuela en un recipiente debidamente etiquetado por el farmacéutico con información de identificación, (nombre del niño, medicamentos dispensados, dosis prescrita y la hora que debe de ser dado o tomado).

Firma del Padre/ Tutor: _____Teléfono: _____ Fecha: _____

O

Autorización del Padre para que su hijo/a se AUTO ADMINISTRE el medicamento (K-5 consulte con la enfermera de la escuela):

- Estoy de acuerdo con la autorización del medicamento como esta escrito por el doctor mencionado arriba.
- Por la presente solicito que mi hijo pueda llevar y auto- administrarse el medicamento en la escuela, como ha sido recetado por el proveedor de salud licenciado de mi hijo. Entiendo que mi hijo debe llevar este medicamento en todo momento en la escuela o el /ella perderá el derecho de llevarlo. Entiendo que la escuela no asume ninguna responsabilidad por la adminitración del medicamento. Por la presente, libero a la Junta Escolar, a sus agentes y empleados, de cualquier y toda responsabilidad que pueda resultar a partir de que mi hijo tome este medicamento. Mi hijo tiene conocimiento de este medicamento y sabe como auto-administrarselo.
- Estoy de acuerdo en asegurar que el medicamento tenga la etiqueta de la farmacia con el nombre de mi hijo/a.

Firma del Padre/ Tutor: _____Teléfono: _____ Fecha: _____

Reviewed by School Nurse: _____ Date: _____