Complete + Return



ALL STUDENTS

STUDENT OVERNIGHT TRAVEL

Student Insurance Waiver Form / Permission to Treut

	i's Full Name:		
Home A	ddress:		
Home Phone#		Parent/Guardian Cell #	
Overnig	tht Student Travel 7	[o:	
TUDE	<u>NT INSURANCE V</u>	V/\text{IVER}	
for over parent/gr imployed ivernight	might travel, student pardian indicating ac es from responsibility f travel.	insurance must be taken unless this insurance waiver form is signed by the dequate personal insurance. This waiver releases the Board of Education and it for any claim due to injuries received while participating in a school-sponsored	
1. (insuant to Board Polic Check one)	by 4220 and the current Student Accident Coverage insurance I wish to proceed as follows:	
.A) I have adequent to the second of the secon	us to personal insurance and release the Board of Education and its employees from an its matter. My medical insurance information follows:	
	Insulance Company	Policy#:	
	Company Phone #:	Name of Insured:	
b	My son/daug understand I am res	ther is already enrolled in the current Student Accident Coverage insurance program.	
c) 2. Ti	understand I am res I need to pu online by going to be there are limitations in	possible for payment of any charges not covered by this policy. It hase the current Student Accident Coverage insurance. I am enrolling my son/daughte It p://www.kandkinsurance.com and following the enrollment instructions. The Student Accident Insurance coverage. The responsibility to pay for any necessar	
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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 o: 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 tal es medicine outside the school hours and will need to take it while on the field frip, 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 nedicine. 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.
 - o 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 n edicines 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 date

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

Dunbar Pam

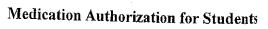
704-,782-0115

School Nurse

Phone



**PRESCRIPTION

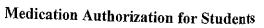




Student's Name:		Rirth Date:	<u> </u>		
In order to keep this student in optimum health and to help maintain maximum school performance and statendance, it is necessary that medication be given during school hours. Name of Medication:					
	*Only one me	edication on each med auth form.			
Circle One: Tablet Capsule *Please indicate physical condi	Liquid Inhaler Neb	pulizer* Patch Drops Injection* Rec lized physical health care (nursing type)	otal* Other: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 predic	cable):				
Termination Date:	(All medica	ation orders expire at the end of the scho	ool year unless otherwise stated.)		
Physician's Signature:		Date:			
Physician's Name Printed:		Telephon	ne #:		
 I hereby give my perm hours. This medication Board and their agents prescribed medication I will furnish all medication 	nission for my child (not have been prescribed as and employees from an interest This consent is good cation for use at school nation, (name of child raken).	ered by the school nurse/staff: named above) to receive medication duri by a licensed physician. I hereby release all liability that may result from my chi for the school year, unless revoked. bl in a container properly labeled by a ph l, medication dispensed, dosage prescrib Phone:	e the School Id taking the parmacist ped, and the		
		OR	-		
I agree to the Medicati I hereby request that me child's licensed health he/she will lose the rigular administration of the ne liability that may result and how to self-adminitiation. I agree to ensure that the	ion authorization as way child be allowed to care provider. I unde the tocarry it. I furthe nedication. I hereby retiron my child taking ister it.	DMINISTERED by their child (K-5 or itten by the above medical provider. It carry and self-administer the medication erstand my child must carry this medicate or understand that the school undertakes release the School Board, its agents and go this medication. My child is knowledge to a pharmacy label with my child's name when the school by the school	on at school as prescribed by my tion at all times in school or no responsibility for the employees, from any and all geable about this medication ne.		
eviewed by School Nurse		Data			



Receta Medica <u>solo</u>





Student's Name:	Birth Date:		
School Year:	Grade:		
In order to keep this student in optimum health	nd to help maintain maximum school performance and sustain		
	ication on each med auth form.		
Circle One: Tablet Capsule Liquid Inhaler Nebul *Please indicate physical condition for which specialize	lizer* Patch Drops Injection* Rectal* Other:ed 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 medicati	ion orders expire at the end of the school year unless otherwise stated.)		
Physician's Signature:	Date: Telephone #:		
Physician's Name Printed:			
 Autorización del padre para que el medicamento se Por la presente, doy autorización para que mi Este medicamento ha sido recetado por un prosus agentes y empleados, de cualquier y toda rel medicamento recetado. Este consentimiento Proporcionaré todos los medicamentos para us farmacéutico con información de identificació hora que debe de ser dado o tomado). 	ea administrado por la enfermera /personal escolar: hijo (nombrado arriba) reciba medicamento durante el horario escolar. oveedor de salud licenciado. Por la presente libero a la Junta escolar, responsabilidad partir que pueda resultar a partir de que mi hijo/a tome to es bueno por el año escolar, a menos que sea revocado. so en la escuela en un recipiente debidamente etiquetado por el on, (nombre del niño, medicamentos dispensados, dosis prescrita y la		
Tima del Ladre, Tulgi.	Teléfono: Fecha:		
Autonigo ción del De J	0		
 Estoy de acuerdo con la autorización del medi Por la presente solicito que mi hijo pueda lleva recetado por el proveedor de salud licenciado o todo momento en la escuela o el /ella perderá e responsabilidad por la adminitración del medic empleados, de cualquier y toda responsabilidad Mi hijo tiene conocimiento de este medicamen Estoy de acuerdo en asegurar que el medicamen 	D ADMINISTRE el medicamento (K-5 consulte con la enfermera icamento como esta escrito por el doctor mencionado arriba. ar y auto- administrarse el medicamento en la escuela, como ha sido de mi hijo. Entiendo que mi hijo debe llevar este medicamento en el derecho de llevarlo. Entiendo que la escuela no asume ninguna camento. Por la presente, libero a la Junta Escolar, a sus agentes y d que pueda resultar a partir de que mi hijo tome este medicamento. nto y sabe como auto-administrarselo. ento tenga la etiqueta de la farmacia con el nombre de mi hijo/a. Teléfono: Teléfono: Fecha:		
eviewed by School Nurse:	Date:		