LAST NAME _____

DUNBAR CHOIR

Field Trip Permission Form

I, the undersigned Parent/Guardian of the student named below, understand the nature of the field trip being planned to the following location:

Disney Trip

Date: March 29-April 2
Location: Disney, Orland, FL
Transportation: Tour Charter Company
Cost to student: $985

STUDENT'S FULL NAME _____ DOB: _____

PARENT'S FULL NAME _____ Emergency Contact #: _____

PARENT/GUARDIAN PERMISSION FORM FOR FIELD TRIPS and MEDICAL INFORMATION

I am in accord with the purposes of and procedures governing the Field trip. I hereby grant permission for my student to participate. I understand that adequate and appropriate supervision will be provided. I recognize, however, that unanticipated situations and problems can arise on any trip, school-sponsored or otherwise, which situations or problems are not reasonably within the control of the supervising teacher(s) or staff (including volunteers). I further agree to release and hold harmless the Fayette County School District Board of Education, their agents, officers, employees and volunteers, from any and all liability, claims, suits, demands, judgments, costs, interest and expense (including attorneys' fees and costs) arising from such activities, including any accident or injury to my student and the costs of medical services.

In the event of an injury requiring medical attention, I hereby grant permission to the supervising teacher(s) or staff (including volunteers) to attend to my student. If the injury warrants further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for necessary medical treatment to be given. In addition, I hereby give my permission to the supervising teacher(s) or staff (including volunteers) to take my student to the Physician, Dentist, or to the hospital if an accident or serious illness occurs on the trip and I cannot be located.

In the event that my student must return to school independently for health, accident, failure to conform to rules established by the teacher in charge, etc. I agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses.

The student's medical form must be on file with the choir office in order to participate in field trips. It is the parent's responsibility to notify us of any changes to the student's medical record.

Parent/Guardian Signature _____ **Date** _____

From FCPS Parent Permission Form for Field Trips

PHYSICIAN ORDER AND PARENT/GUARDIAN AUTHORIZATION FOR SELF MEDICATION ADMINISTRATION

(Please complete one form for each medication.)

Student's Name: _____ **DOB:** _____

Allergies: _____

Medication: _____ **Dosage:** _____

Reason for medication or diagnosis: _____

School: _____ **School Year:** _____

In order for students to self-administer medication at school, the Parent/Guardian shall provide this signed authorization form. Also, a Physician's Order (see box below) is required for students to self-administer medication. Please be sure to complete ALL of the information on this authorization form before returning it to school. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

* It is recommended that only middle and high school students are allowed to carry and self-administer their own medication. For elementary age children, arrangements can be made to keep inhalers or emergency medications in the classroom. The student's teacher will provide monitoring for the child's safety.

Please note, per policy, no student may carry or self-administer a controlled substance.

PHYSICIAN'S ORDER

1. I have examined this student for (diagnosis): _____ and have determined that he/she requires medication during school hours.
2. Name of Medication _____ 3. Dosage & Route: _____
4. I believe this student is able to carry and administer his or her own medication (excluding controlled substances) at the appropriate time and in the appropriate way. **Please check: ____YES _____ NO**

I understand that self-administered medication is not provided by or monitored by the School Nurse or school staff.

Physician's Signature: _____ **Date:** _____ **/** _____ **/** _____

Printed Name: _____ **Phone:** _____

PARENT/GUARDIAN STATEMENT

☐ *I, the undersigned Parent(s)Guardian(s) of* _____ *give consent for* *****my student to self-administer*** *the above medication(s). I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I understand that self-administered medication is not provided by or monitored by the School Nurse or school staff.*

The School Nurse reserves the right to monitor student periodically during the school year.

* ***Parent / Student are responsible to have the medication available at school.***

X _____ _____ **/** _____ **/** _____

(Parent/Guardian Signature) Date

Home Phone: _____Work**:** _____Cell: _____

Reviewed by: _____ RN Date: _____