Field Trip to: _____ LAST NAME _____

lafayette choir BOOSTERS

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.

STUDENT'S FULL NAME _____ DOB: _____

Please list any medical concerns or past medical history of which we should be aware:

_____

_____

Please check below if you student has allergy or sensitivity that needs to be accommodated on this trip:

☐ Bee Sting ☐ Nuts ☐ Dairy ☐ Latex ☐ Other: _____

☐ Asthma ☐ Diabetes ☐ Seizure Disorder ☐ Heart Condition ☐ Other: _____

** If my student requires medication, I understand that I am obligated to ensure that the medication and the (FCPS) Medication Authorization Form are on file prior to the trip and I will supply the medication in the original container on the day of the trip. For a student to self-administer any medication (prescription or non-prescription) the Self-Administration Form must be completed by their parent/guardian and physician. Please note, school staff is NOT responsible for self-administered medications. Controlled substances may NOT be self-administered.

INSURANCE COMPANY_____ POLICY NUMBER _____

SUBSCRIBER NUMBER_____ GROUP NUMBER _____

PERSONAL PHYSICIAN_____ PHYSICIAN'S PHONE _____

Parent Home: _____ Parent Work: _____

Parent Cell 1: _____ Parent Cell 2: _____

Additional Emergency Contact: _____ Relationship: _____

Parent/Guardian Signature _____ **Date** _____

****PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK) ****

lafayette choir BOOSTERS

LAST NAME _____

OVER THE COUNTER (OTC) MEDICATIONS MUST BE AUTHORIZED BY PARENT INITIALS BELOW

Ibuprofen (Motrin, Advil) 200 mg - 1 to 2 tablets every 4 to 6 hours as needed for discomfort, no more than 6 tablets in 24 hours.

_____ yes _____no

Acetaminophen (Tylenol Extra Strength) 500mg - 2 tablets every 6 hours as needed for discomfort, no more than 8 tablets in 24 hours.

_____ yes _____no

Diphenhydramine (Benadryl) 25 mg - ½ to 1 tablet every 4 to 6 hours as needed for relief of allergy symptoms including itching, no more than 6 in 24 hours.

_____ yes _____no

Antacid Calcium Rich (Tums, Rolaids) chew 2-4 tablets for symptoms, no more than 10 in 24 hours

_____ yes _____no

Loperamide (Imodium) 2 mg chew 2 tablets after first loose stool then one after each subsequent stool not to exceed 4 tablets in 24 hours as needed for diarrhea.

_____ yes _____no

Simethicone (Gas X) 125 mg chew 1 or 2 tablets after meals and at bedtime if needed for abdomen pain related to gas pain and pressure not to exceed 4 in 24 hours.

_____ yes _____no

Meclizine Hydrochloride (Dramamine) 25 mg - 1 or 2 tablets as needed once a day one hour before activity that may lead to motion sickness, not to exceed 2 tablets in 24 hours.

_____ yes _____no

I, the undersigned Parent/Guardian, hereby give my permission for _____ to take the OTC medications I have authorized above in accordance with the directions explicitly described for each medication. I understand that, in order for school personnel or authorized chaperones to administer any type of medication to my child, I must provide this completed and signed authorization form ***including both my initials next to applicable blanks above and signed below***. I understand that medication will be dispensed to the student by staff or chaperones. I understand that the medicine must be brought to the school with complete instructions and in the **original** container with the Physician's order **or** pharmacy label firmly attached to the medication. I further understand that medication to be administered on a trip must be brought to school by the Parent/Guardian and that all medications and paperwork for overnight trips must be turned in at least one week prior to the trip.

I, the undersigned Parent/Guardian, request that an authorized staff member or chaperone administer the medication authorized by me on this form to my child. For prescription medications, I agree to furnish the necessary prescribed medication and agree to notify the School Nurse and Lafayette Choir medical designee immediately of any changes. I understand the Fayette County Board of Education Medication Policies and Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks after the trip or the medication will be destroyed.

Parent/Guardian Signature _____ **Date** _____

I, the undersigned Parent/Guardian, hereby give my permission for the Lafayette Choir or representatives on their behalf to seek medical attention for _____in the event it is deemed advisable for his/her welfare. I give consent for a qualified physician or surgeon to examine, diagnose, prescribe and perform treatment, including surgery. If an operative procedure is recommended, I hereby consent to the administration of any anesthetic, general, local or both by a qualified anesthesiologist. If a blood transfusion is necessary, I consent to this procedure. I understand that no one connected with Lafayette High School or the Lafayette Chorus Boosters assumes liability for any injury incurred by the participant. I agree to pay all costs incurred by the participant(s) for the hospital bills, physician fees, and ambulance fee.

Parent/Guardian Signature _____ **Date** _____