Overnight Travel Procedure for Student Medication

Dear Parent/Guardian,

Follow the guidelines below if your child needs medicine during the overnight 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 overnight trip to be given, as ordered, by the teacher/chaperone. No additional paperwork is needed.**

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

    - **Prescription or over-the-counter medicine to be given by school staff** must have a Medication Authorization order completed and signed by a medical provider. Parent must sign the order allowing school staff to give medicine. Medicine must be sent in a pharmacy bottle with prescription label or in the original container with student's name and least amount needed. Medicine and order must be given to the School Nurse to review before the trip.

    - **Prescription medicine to be self-administered by the student** must have a Medication Authorization order completed and signed by a medical provider. Parent must sign the order allowing the student to self medicate. Student will meet with the School Nurse to complete self-medication contract before the trip. Medicine must be sent in the original container with prescription label and least amount needed. Medication Authorization must be given to the School Nurse to review before the trip.

    - **Over the counter (OTC) medicines to be self-administered by the student** must be noted on the treatment permission form included in this packet. All OTC medicine should be sent in its original container with student's name on it and least amount needed.

All Medication Authorization orders and/or medicines for the overnight trip are due to the School Nurse to review by

_____.

Date

Please call if you have any questions.

_____ _____

School Nurse **Phone**

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.kandkinsurance.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**: _____

Medication Authorization for Students

Complete for any prescripton or over-the-counter medications that teachers will administer which are not already ordered during the school day.

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: _____

Circle One: Tablet Capsule Liquid Inhaler Nebulizer* Patch Drops Injection* Rectal* Other : _____

*** The Special Health Care Procedure statement must be completed on back for medication via nebulizer, injection or rectum ***

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 to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed health care provider. I hereby release the School Board, its agents and employees, from any and all liability that may result from my child taking prescription and non-prescription medication. I am in full agreement to supply this medication as needed.
Signature of Parent/Guardian: _____

Telephone: _____ Date: _____

OR

Parent Permission for medication to be SELF-ADMINISTERED by their child (K-5 consult with School Nurse)
I hereby request that my child be allowed to carry and self-administer the above inhaler, insulin, Epi-pen or other prescription 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. **(Student contract must be signed of back.)**
Signature of Parent/Guardian: _____

Telephone: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____