

Parma High School Washington, DC Trip 2020

Dear Parents:

Please find the attached "**Parents' Approval Form—Educational Trips Overnight / Out-of-State / Out-of-the-Country.**" Parents are asked to neatly print all the information that is requested. Please note that the medical insurance info (company name, policy number, account number, etc.) is especially vital in the event your child is ill or injured while on the trip. Pages **6& 7** require the signatures of both parents, or the signature of a single parent having sole legal custody of the child.

Pages **8 & 9** of the packet are only to be completed IF the student will be, or could be taking prescription medication while on the trip. Note that page **8** requires a PHYSICIAN'S signature. If your child is not currently taking any prescription medication, it is not necessary to complete pages **8 & 9**. However, it may be a good idea to save pages **8 & 9** in a safe place in case it is necessary for your child's doctor to prescribe medication between now and April 24, 2019.

Pages **2-7** must be returned by: **February 3rd, 2020**

Pages **8 & 9** (if applicable) need to be returned as soon as possible.

Thanks you for your cooperation in this important matter to ensure the fun and safety of your child!

Mr. Connors – connors@parmacityschools.org

Paul Gerycz - geryczp@parmacityschools.org

Washington, DC Trip Coordinators

PARENTS' APPROVAL WAIVER FROM
EDUCATIONAL TRIPS
OVERNIGHT / OUT-OF-STATE / OUT-OF-COUNTRY

Dear Parents:

Your child is eligible for participation in an educational trip described below. The following form is divided into four sections which: **(1)** identify your child and the trip for which he/she is eligible; **(2)** provide pertinent medical data; **(3)** establish a procedure for emergency treatment; **(4)** set forth the conditions and limitations upon Board liability in connection with your child's participation. Please read the form carefully and provide the necessary data. No child will be permitted to participate in the trip unless he/she has first submitted a completed form, signed by both parents or by a single parent having sole legal custody of the child.

SECTION (1)

Student's Name

| Last | First | Initial |
|------|-------|---------|
| | | |

Student's Address

| |
|-----------------------|
| House Number & Street |
| |

| City | Zip Code |
|------|----------|
| | |

Student's School

| |
|-------------------|
| Parma High School |
|-------------------|

Name of Trip

| |
|----------------|
| Washington, DC |
|----------------|

Students will be traveling by chartered bus **to** Washington, DC **and will leave** Parma High (Front bus loop) **at** 7:00 A.M. **on** Wednesday, May 13. **Students will be returning to** Parma high (Back bus loop) **at approximately** 07:30 P.M. **on** Friday, May 15, 2020.

SECTION (2)

(CIRCLE)

| | | |
|--|------------|-----------|
| Is this your child's first trip away from home without parents? | YES | NO |
|--|------------|-----------|

| | | |
|---|-----|----|
| Is your child susceptible to motion sickness? | YES | NO |
|---|-----|----|

| |
|--|
| Please list any food or drug allergies your child has |
| |

| | |
|--|--|
| Date of child's last tetanus shot | |
|--|--|

| | | |
|---|-----|----|
| Does your child have any medical conditions of which the school personnel should be aware? (Example: heart condition, diabetes, seizures, recent injuries, or illness) | YES | NO |
|---|-----|----|

| |
|-------------------------------|
| If YES please explain: |
| |

If your child is currently taking any medication, prescription or over-the-counter, which he/she will be taking during the trip please fill out the following charts:

OVER-THE-COUNTER:

| √ | Medication | Dosage | Time to Administer | Purpose of Medication | Special Instructions |
|---|----------------------------|--------|--------------------|-----------------------|----------------------|
| | Acetaminophen (Tylenol) | | | | |
| | Ibuprofen (Advil/Motrin) | | | | |
| | Antacid (Tums) | | | | |
| | Dimenhydrinate (Dramamine) | | | | |
| | Diphenhydramine (Benadryl) | | | | |
| | (Inhaler) | | | | |
| | | | | | |
| | | | | | |

SECTION (2) continued...

****All OTC medication should be placed in a Ziploc bag with the student's name, bus #, parent contact #. OTC medication must be turned in to the nurse on departure day.**



| |
|---|
| Student Name Bus Number Parent Contact Phone number |
|---|

PRESCRIPTION MEDICATION

To request and give consent to authorized PCSD school personnel to administer the medication(s) to my child. I will provide the medication in accordance with the Parma City School District Procedure, Code JHCD, Section J: Students, you must supply written permission and directions for administering said medication by having the physician fill out Form B and the parent fill out Amended Form C.

(circle)

| | | |
|---|------------|-----------|
| Do you have medical insurance which covers your child? | YES | NO |
|---|------------|-----------|

(IF YES)

| Name of Insurance Company | Policy or Contract Number |
|----------------------------------|----------------------------------|
| | |

| |
|---|
| Any other information of which you feel the staff should be aware? |
| |

Parent/Guardian Contact Information

| | |
|-------------------------------|--|
| Mother/Guardian's Name | |
|-------------------------------|--|

| | |
|-------------------------|--|
| Home Address | |
| Home Phone | |
| Cell Phone | |
| Place of Work | |
| Business Address | |
| Business Phone | |

| | |
|-------------------------------|--|
| Father/Guardian's Name | |
| Home Address | |
| Home Phone | |
| Cell Phone | |
| Place of Work | |
| Business Address | |
| Business Phone | |

| | |
|-----------------------|--|
| Doctor's Name | |
| Business Phone | |

| | |
|-----------------------|--|
| Dentist's Name | |
| Business Phone | |

| | |
|---------------------------------|--|
| Emergency Contact Person | |
| Home Address | |
| Home Phone | |
| Cell Phone | |
| Place of Work | |
| Business Address | |
| Business Phone | |

SECTION (3)

EMERGENCY TREATMENT

In the event that my child should become ill or injured during the course of this educational trip, I request that you make reasonable attempts to contact me. In the event of reasonable attempts to contact me at

(Home Phone No.) _____ **or (Work Phone No.)** _____

or **(Other Parent)** _____

(Home Phone No.) _____ **or (Work Phone No.)** _____

have been unsuccessful. I hereby give my consent for: (1) the administration of any treatment deemed necessary by a licensed physician; and (2) the transfer of the child to a hospital or emergency facility as deemed necessary by the school personnel and/or physician

| Parent/Guardian Signature | Date |
|----------------------------------|-------------|
| | |

| Parent/Guardian Signature | Date |
|----------------------------------|-------------|
| | |

SECTION (4)

Conditions and limitations in connection in connection with this educational trip.

- a. It is understood and agreed that portions of this trip may be rescheduled, postponed or cancelled due to strikes, sickness, quarantine, government restrictions or regulations, acts of God, or acts of omissions of, or damaged or malfunctioning property owned by any service or transportation company, firm, individual or agency, and that neither the Board of Education, of the Parma City School District, its members, officers, employees, group leaders, nor chaperones shall be held responsible therefore.
- b. It is expressly understood and agreed that the child and parent assume all risk of harm, injury, loss which the child may incur during the course of this trip and that, as a result, the undersigned expressly waive and release the Board of Education of the Parma City School District from any and all such claims of liability, including but not limited to claims arising from emergency care in the manner hereinabove directed. The waiver and release shall include, but not be limited to, claims arising while the student is on "Free Time" and while the student is absent from the group for other reasons authorized by the parent in writing in advance.
- c. It is further understood and agreed that the child shall comply with all rules and regulations of the Board of Education including suggestions, recommendations, rules and regulations of chaperones and staff members, in all matters pertaining to the program or personal conduct, and that failure to do so shall be grounds for immediate

termination of the child from the trip and his/her being returned home at the parents' expense, without return of any other trip fees.

- d. The Board reserves the judgment of canceling any field trip in the United States or Canada based upon concerns for the safety and welfare of students/staff/chaperones.

I have read, understand, and accept all of the above-stated conditions.

| Parent/Guardian Signature | Date |
|----------------------------------|-------------|
| | |

| Parent/Guardian Signature | Date |
|----------------------------------|-------------|
| | |

| Child/Student Signature | Date |
|--------------------------------|-------------|
| | |

**FORM B
PHYSICIAN'S REQUEST
FOR THE
ADMINISTERING OF MEDICATION BY SCHOOL PERSONNEL**

(Name of Student) _____ is under my care and should receive:

| Name of Medication | Dosage | Administration Instructions | Diagnosis or reason needed | Possible Side Effects | Expiration date of this request |
|--------------------|--------|-----------------------------|----------------------------|-----------------------|---------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |

| |
|--------------------------|
| Physician (print) |
| |

| Physician's Signature | Date |
|------------------------------|-------------|
| | |

| |
|----------------|
| Address |
| |

| |
|---------------------|
| Phone Number |
| |

**AMENDED FORM C
PARENT / GUARDIAN PERMISSION
TO ADMINISTER MEDICATION**

TO: Principal _____

School _____

DATE: _____

I the undersigned parent/guardian of _____ hereby grant permission and specifically the staff of _____ School to administer the dosage of the medication prescribed by a licensed physician, whose instructions are attached (Form B)

In making this request, I understand:

1. That the school is rendering this service upon my specific request
2. That I absolve the staff of the school from any liability arising from the administration of this medication.
3. That the medication be sent to the appropriate school official in a container marked with:
 - a. Name of student
 - b. Name of medication, dosage, and time to be given
 - c. Name of pharmacy and prescription number
4. It is not the responsibility of the school personnel to remind the child to take the medication at the appropriate time.

I, _____, having given full consideration to the ramifications hereof, hereby expressly and voluntarily agree for on behalf of myself and my child _____, that I absolve the Board of Education of the Parma City School District and all its officers, agents and employees of any and all liability which may arise in any way from the administration of medication to my child as I have requested, and for and on behalf of myself and my child, I waive and forever release any and all claims of any nature which may arise in connection therewith.

Witness:

In the presence of:

Signed _____
(Signature of Parent/Guardian)

Signed _____
(Signature of Parent/Guardian)

MUST BE SIGNED BY BOTH PARENTS UNLESS CUSTODY HAS BEEN AWARDED TO ONE PARENT

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