Name_____(last, first)

2020 HARVEY RED RAIDER MARCHING BAND CHICAGO, IL TRIP FORMS PACKET

Forms due March 11, 2020

2020 Harvey Red Raider Marching Band Chicago, IL Trip

May 1-3, 2020

Phone

- (440) 392-5171-Mr. Jones
- (440) 392-5313-Mr. Amos
- (440) 392-5127-Mr. Ferron

Email:

amir.jones@pcls.net
david.amos@pcls.net
nate.ferron@pcls.net

200 W. Walnut Ave. Room 404
Painesville, Ohio 44077

2020 HARVEY RED RAIDER MARCHING BAND CHICAGO, IL TRIP PERMISSION SLIP

I give my student permission to travel overnight and out of state to Illinois with the Harvey Red Raider Marching Band to participate in the activities as outlined in the trip itinerary and approved by the Painesville City Local Schools Board of Education.

Parent Name (print)

_____

Parent Signature

_____

Date

_____

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HHS BANDS

200 W. Walnut Ave. Room 404
Painesville, Ohio 44077

CONSENT TO SEARCH FORM

For the safety of our students, every overnight bag, and student carry-on bag will be searched prior to our departure. The belongings of each student will only be searched by a staff member of the same gender.

- -

I authorize the search of my child's belongings by a staff member.

Principal

_____

Parent Name (print)

_____

Parent Signature

_____

Date

_____

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RESPONSIBILITY CONTRACT FOR OVERNIGHT TRIPS

It is a privilege for you to participate in the District-sponsored trip to Illinois. Because this trip is part of the District's educational program, it is imperative that you adhere to the Code of Conduct for overnight trips as well as the applicable provisions of the general Code of Conduct. You must remember that from the time of departure to your arrival home, you are the responsibility of the District.

I agree to:

A. refrain at all times from the consumption of alcoholic beverages and/or drugs unless said drugs are prescribed by a physician and dispensed by school personnel or self-medication and/or possession are properly authorized;

B. sleep in my assigned room and not entertain members of the opposite sex in my room, unless my room door is fully opened, and an adult chaperone is notified;

C. keep my assigned chaperone advised of my whereabouts at all times;

D. attend all mandatory activities and meal functions;

E. adhere to all established curfews;

F. conduct myself in such a manner as to bring pride to myself, my family, my school, and my community;

G. adhere to any established dress code;

H. comply, throughout the trip, with any and all instructions directed to me and/or the group by a chaperone or staff member.

If a problem arises that is serious enough in nature to warrant the below-named student's removal from the travel group, we (the student and parent/guardian) agree to bear any additional costs to return the student home. NOTE: This removal decision will be made by the accompanying professional staff member after a student has been provided the opportunity to respond to any allegations. The student may also be subjected to discipline upon return home in accordance with general District policies.

_____ _____

Student Date

_____ _____

Parent Date

PARENT CONSENT FOR PARTIALLY-UNSUPERVISED TRIP

I, _____ (Parent's Name), permit my child,

_____, to participate in the trip to

Illinois.

☐ I understand that this trip is part of the District's educational program and provides a learning experience of educational value to my child.

☐ I further understand that the staff member(s) who will accompany the students on this field trip, will exercise the necessary and appropriate duty of care for them pursuant to Board Policy 3213, including, but not limited to, administering medication, if required, or seeking emergency medical attention, if need be.

☐ I further understand that the following activities associated with this trip are such that my child cannot be supervised by school staff during certain segments of the trip:

Visiting parks, shopping, group tours, and in the Hotel Rooms

_____

_____

_____

_____

_____

_____

_____

☐ I agree that I have been adequately informed about the unsupervised portion of the trip and shall hold the District harmless from any liability for my child's welfare while s/he is participating in those unsupervised activities.

_____
Parent

_____
Date

EMERGENCY MEDICAL AUTHORIZATION

School: _____ Student Name: _____

Address: _____

Telephone: _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian
Mother's Name: _____ Daytime Phone: _____
Father's Name: _____ Daytime Phone: _____
Other's Name: _____ Daytime Phone: _____
Name of Relative or Childcare Provider: _____ Relationship to Child: _____
Address: _____ Phone: _____

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Emergency Room Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____

PART II – REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____

R.C. 3313.72

Supplemental Information (optional):

Student's Birthdate: _____ Grade:_____

Teacher/Homeroom: _____

Date of Last Tetanus: _____

Student resides with (circle all that apply) Mother Father Stepparent Guardian Other: _____

_____

Additional Contact Information for those who have authority to make decisions in an emergency situation involving this student.

Mother: _____ Home#: _____ Work#: _____ Mobile#: _____

Father: _____ Home#: _____ Work#: _____ Mobile#: _____

Stepparent: _____ Home#: _____ Work#: _____ Mobile#: _____

Guardian: _____ Home#: _____ Work#: _____ Mobile#: _____

Alternate: _____ Home#: _____ Work#: _____ Mobile#: _____
(relative child car provider)

8/14/06

AUTHORIZATION FOR PRESCRIBED MEDICATION/DRUG OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Address

_____ _____
School Grade

A. I am requesting permission for my child named above to: (Check all that apply)

_____ use or receive prescribed medication

_____ receive prescribed treatment

_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member

_____ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336

in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school, except for diabetes medication student is permitted to posses pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly from this authorization

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student named on this form..

I have prescribed the following medication _____

_____

_____

Beginning Date _____ Ending Date _____

Dosage, instructions, or precautions (including possible side effects): _____

_____

_____

_____

I have prescribed the following treatment _____

_____

_____

_____

_____

_____

Beginning Date _____ Ending Date _____

For student with diabetes only:

_____ I authorize the student to attend to his/her diabetes care and management, in accordance with my order, during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

Prescriber's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

School Nurse, Amir Jones, David Amos, Johnathen McClain, Nate Ferron

Principal

5/07
8/10/15

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT
(SECONDARY VERSION)

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Address

_____ _____
School Class/Grade

A. I am requesting permission for my child named above to: (Check one or both)

[ ] use or receive the following over-the-counter medication(s).

Medication: _____

Dosage: _____

Check Option 1 or 2 below.

[ ] self-administer such medication(s) in the presence of an authorized staff member.

[ ] keep the medication(s) in his/her possession and self-administer the medication(s) as needed.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatment(s):
School Nurse, Amir Jones, David Amos, Johnathen McClain, Nate Ferron

_____

Van McWhirt

_____
Principal