Name (last, first)

# 2020 HARVEY RED RAIDER WARCHING BAND CHICAGO, IL TRIP FORWS PACKET

Forms due March 11, 2020



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**Pg. 3 Overnight Trip Responsibility Forms** 

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**Pg. 10 Non-prescribed Medication Form** 

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:**

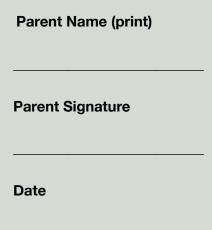
amir.jones@pcls.net david.amos@pcls.net nate.ferron@pcls.net



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

# 2020 HARVEY RED RAIDER WARCHING BAND CHICAGO, IL TRIP PERWISSION 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.





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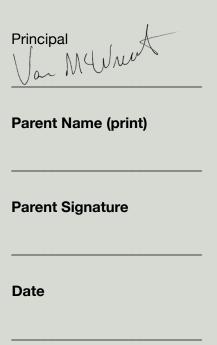


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# **CONSENT TO SEARCH FORM**

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.





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# RESPONSIBILITY CONTRACT FOR OVERNIGHT TRIPS

		or you to participate in the District-sponsored trip to  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 ust remember that from the time of departure to your arrival home, you are the
	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;
	В.	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.
*	the travel group, v student home. N member after a st	s that is serious enough in nature to warrant the below-named student's removal from ve (the student and parent/guardian) agree to bear any additional costs to return the OTE: This removal decision will be made by the accompanying professional staff udent has been provided the opportunity to respond to any allegations. The student cted to discipline upon return home in accordance with general District policies.
<b>→</b>	Student	
<b>→</b>	Parent	Date

# PARENT CONSENT FOR PARTIALLY-UNSUPERVISED TRIP

I,	(Parent's Name), permit my child,
	, to participate in the trip to
<u>Illir</u>	nois
	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:
Visitir	ng parks, shopping, group tours, and in the Hotel Rooms
П	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.
Paren	t
Date	

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# **EMERGENCY MEDICAL AUTHORIZATION**

School:	Student Name:
	Address:
	Telephone:
Purpose - To enable parents and guardians to authinjured while under school authority, when parents of	norize the provision of emergency treatment for children who become ill or or guardians cannot be reached.
Other's Name:	Daytime Phone: Daytime Phone: Daytime Phone: Relationship to Child: Phone: 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:
any treatment deemed necessary by above-nam	e been unsuccessful, I hereby give my consent for (1) the administration of ed doctor, or, in the event the designated preferred practitioner is not and (2) the transfer of the child to any hospital reasonably accessible.
This authorization does not cover major surgery ur concurring in the necessity for such surgery, are ob-	aless the medical opinions of two (2) other licensed physicians or dentists, tained prior to the performance of such surgery.
Facts concerning the child's medical history include which a physician should be alerted:	ding allergies, medications being taken, and any physical impairments to
Date: Signature of Parent/G	uardian:
Address:	

# PART II - REFUSAL TO CONSENT

	for emergency medical treatment of I authorities to take the following acti		ess or injury requiring emergency
Date:	Signature of Parent/Guardian:		
R.C. 3313.72			
	Supplemental Info	rmation (optional):	
Student's Birthdate:			Grade:
Teacher/Homeroom:			
Date of Last Tetanus:		-	
Student resides with (circle	all that apply) Mother Father	Stepparent Guardian O	other:
Additional Contact Informa student.	tion for those who have authority to n	nake decisions in an emergen	ncy situation involving this
Mother:	Home#:	Work#:	Mobile#:
Father:	Home#:	Work#:	Mobile#:
Stepparent:	Home#:	Work#:	Mobile#:
Guardian:	Home#:	Work#:	Mobile#:
Alternate:(relative child car provider)	Home#:	Work#:	Mobile#:
(relative critic car provider)			

8/14/06

# AUTHORIZATION FOR PRESCRIBED MEDICATION/DRUG OR TREATMENT

To the Parent:

Nam	ne of Student	Address
Sch	ool	Grade
A.	I am requesting permission for my child  use or receive prescribed  receive prescribed treatments	
	staff member	I medication(s) in my presence or that of an authorized only: self-administer diabetes care in accordance with
В. С. D.	medication student is permitted to poss I will notify the school immediately if the prescribed treatment, or if I wish to revo- I release and agree to hold the Board of	ivery of the medication/drug to school, except for diabetes les pursuant to Policy 5336. ere is any change in the use of the medication/drug or the
Sigr	nature of Parent	Date
Hom	ne 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 prescrib	have prescribed the following medication						
Beginning Date	)	Ending Date					
Dosage, instruc	ctions, or precautions (includi	ing possible side effects):	<del></del>				
I have prescrib	ed the following treatment						
Beginning Date	)	Ending Date					
For student w	ith diabetes only:						
	accordance with my orde	o attend to his/her diabetes care and rer, during regular school hours and scied that the student is capable of performing	hool sponsored				
Prescriber s Sig	gnature	Telephone					
Printed/Typed Name Date							

### **AUTHORIZATION FOR STAFF**

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

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

Jan M. Wheet

5/07 8/10/15

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# <u>AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT</u> (SECONDARY VERSION)

Nam	e of Student	Address					
Scho	ool	Class/Grade					
A.	I am reque	esting 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.					
В.	l will assur	will assume responsibility for safe delivery of the medication to school.					
C.		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 of indirectly from this authorization.						
Sign	ature of Pare	ent Date					
Hom	e Telephone	Work Telephone					
		AUTHORIZATION FOR STAFF					
	following ication(s)/trea nool Nurse	staff members are authorized to administer the above-nonprescribed atment(s): e, Amir Jones, David Amos, Johnathen McClain, Nate Ferron					
		Van M. Whut Principal					

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