Omak High School

Omak School District
619 W. Bartlett Ave
Omak, WA 98841
Phone (509) 826-5150 / Fax (509) 826-8515

OHS FIELD TRIP/SCHOOL ACTIVITY PERMISSION FORM

Today's Date: ___________

Dear Parent/Guardian:

The ______________________________ class is going to be taking a field trip on ____________
(Class/subject) (Date)
to ______________________________ as an extension of the classroom learning process.
(Field trip location)

We assure you that every step will be taken in order to have a safe learning experience. We request that you give your son/daughter permission to participate in the field trip. If you have any questions, feel free to contact the Omak High School.

X__________________________
(Signature of Teacher/Advisor)

I hereby give my permission for (Print Student Name) ______________________ to participate in the field trip. I pledge that my conduct will at all times reflect credit upon myself, parents and school.

X__________________________
(Signature of Student)

If an emergency arises while your child is participating in an activity away from home, do you consent to an examination and/or treatment by a physician at the local doctor's office/hospital?
Yes_______ No______ If your answer is "No" please specify procedures you wish the district staff member to follow: ____

____

Name of Insurance Company ________________________ Policy Number ________________

____

Does your child need to take medication while on this trip? (**Please circle one**) YES NO

If your child requires medication while on this trip, the medication may only be given if it is in the current, properly labeled container. **All medication (including asthma inhalers) must be accompanied by the proper authorization form (page 2 - on back side of this form)** and must be completely filled out by the physician and parent/guardian. Medication must be brought to the school by a parent/guardian and checked in by a designated staff member trained to receive and distribute the medication, (School Nurse). As per school policy, students are not allowed to carry medication with them (asthma inhalers are the exception ONLY with authorization form signed by physician and parent). If you have a question regarding medication please contact our school nurse.

Print parent name and address

____

____

X____________________________ ____________________
(Signature of Parent/Guardian) (Contact phone number)

Medication Authorization

For Oral and Emergency Injected Medication Administration at School

Student Name: Birth Date:

School: Omak High School 826-8395/Fax 826-8515 Grade:

LICENSED HEALTH PROFESSIONAL (LHP)

Complete this section using one form for each medication

Diagnosis or reason for medication: ____________________

Severity of the problem: ❑ mild ❑ moderate ❑ severe

Activity modifications or restrictions: ____________________

Name of Medication	Dosage	Method of administration	Time to be given or frequency if PRN

**For oral antihistamine, describe signs or symptoms when to use:____________________

**For EpiPens, describe signs or symptoms when to use: ____________________

Possible side effects of medications:____________________

Can the student travel on field trips > 30 minutes away from emergency medical response? ❑ yes ❑ no

Student has been instructed in the correct way to use this medication. ❑ yes ❑ no

Student has demonstrated the skill level necessary to use the medication appropriately without supervision. ❑ yes ❑ no

Student may carry and self-administer the medication ordered above. ❑ yes ❑ no

I request and authorize that the above-named student be administered or self-administer this oral medication according to the instructions indicated above from ___/___/___ to ___/___/___ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Date of Signature *Licensed Health Professional*

Phone / *FAX* *Name (Print)*

PARENT or GUARDIAN

To complete this section

I request and authorize the school to administer medication to the above student in accordance with the LHP's instructions for the period from ___/___/___ to ___/___/___ (not to exceed the current school year). I understand that information about this medication and health problem will be shared with school staff that need to know.

My child can carry and self administer this medication at school ❑ yes ❑ no

If I give permission for my child to carry and self-administration medication, I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

Date of Signature *Parent/Guardian Signature*

Home Phone *Work or Cell Phone*

Reviewed by RN/LPN: ____________________ on ___/___/___