CABARRUS COUNTY SCHOOLS
OVERNIGHT TRAVEL
MEDICAL PACKET

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: _____

Student's Name: _____ Grade: _____

Physician and Parent Authorization for Special Health Care Procedure

This is to verify that the above named student has the following physical condition for which specialized physical health care (nursing type) procedure is to be provided: _____

Procedure: Medication delivered via (circle one): Injection Rectum Nebulizer Feeding Tube Other: _____

Physician's Signature: _____ Date: _____

I hereby request that the procedure specified above be performed on or for my above named child.

Parent/Guardian's Signature: _____ Date: _____

Student Contract for Self-Administered Medication

Student Responsibilities:

- I plan to keep my inhaler, equipment, Epi-pen or other medication with me at school rather than in the school nurse's office.
- I agree to use my inhaler, equipment, Epi-pen or other medication in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the school health office or main office if I am having more difficulty than usual with my health condition.
- I will not allow any other person to use my inhaler, equipment, Epi-pen or other medication.
- I will carry the least amount of medication possible in its original container.

Student's Signature: _____ Date: _____

School Nurses Responsibilities:

- Emergency Action Plan complete and on file at school
- Demonstrates correct use/administration
- Recognizes proper and prescribed timing for medication
- Agrees to carry medication or keep in an established location
- Knows health condition well
- Keeps a second labeled container in the health room
- Will not share medication or equipment with others.

Comments:

School Nurse Signature: _____ Date: _____

Policy for Over-the-Counter Medication Self-Administered by Students:

When a student self-administers an OTC medication without school staff support, the drug must be sent in the original container with only 1or 2 doses with a written authorization signed by the parent and attached to the container. The authorization must also include the date, time and amount of medication to be self-administered by the student.

Medication Authorization for Students

Complete para cualquier prescripton o medicinas sin receta los maestros administrará que no ya es ordenado durante el día lectivo.

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 #: _____

Autorización del Padre: Firme la autorización correspondiente a su hijo a continuación.

Autorización del Padre para que la medicación sea suministrada por la enfermera/personal escolar

Por la presente, doy autorización para que mi hijo reciba la medicación durante el horario escolar. Entiendo que la escuela no tiene responsabilidad por el suministro de la medicación. Esta medicación fue prescripta por un proveedor licenciado de cuidado médico. Por la presente, libero a la Junta Escolar, a sus agentes y empleados, de cualquiera y todas las responsabilidades a partir de que mi hijo tome una medicación prescripta o no prescripta. Estoy totalmente de acuerdo en el suministro de esta medicación cuando sea necesario.

Firma del Padre/ Tutor: : _____

Telephone: _____ Date: _____

OR

Autorización del Padre para que el niño se AUTO SUMINISTRE la medicación (K-5 consultar con la Enfermera Escolar)

Por la presente, solicito que se autorice a mi hijo a transportar y auto suministrarse el inhalador nombrado más arriba, insulina, Epi-pen u otra medicación prescripta en la escuela, de acuerdo con lo indicado por el proveedor licenciado de cuidado médico de mi hijo. Entiendo que mi hijo debe transportar esta medicación en todo momento en la escuela o perderá el derecho de transportarla. Entiendo que la escuela no tiene responsabilidad por el suministro de la medicación. Por la presente, libero a la Junta Escolar, a sus agentes y empleados, de cualquiera y todas las responsabilidades a partir de que mi hijo tome esta medicación. Mi hijo conoce la medicación y sabe cómo auto suministrársela. **(El contrato del estudiante se deberá firmar en el reverso)**

Firma del Padre/ Tutor: _____

Teléfono: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Student's name: _____ Grade: _____

Physician and Parent Authorization for Special Health Care Procedure

This is to verify that the above named student has the following physical condition for which specialized physical health care (nursing type) procedure is to be provided: _____

Procedure: Medication delivered via (circle one): Injection Rectum Nebulizer Feeding Tube Other: _____

Physician's Signature: _____ Date: _____

Por la presente, solicito que el procedimiento especificado más arriba sea realizado sobre o para mi hijo, quien se nombra más arriba.

Firma del Padre/Tutor: _____ Fecha: _____

Student Contract for Self-Administered Medication

Student Responsibilities:

- I plan to keep my inhaler, equipment, Epi-pen or other medication with me at school rather than in the school nurse's office.
- I agree to use my inhaler, equipment, Epi-pen or other medication in a responsible manner, in accordance with my licensed health care provider's orders.
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- I will not allow any other person to use my inhaler, equipment, Epi-pen or other medication.
- I will carry the least amount of medication possible in its original container.

Student's Signature: _____ Date: _____

School Nurses Responsibilities:

- Emergency Action Plan complete and on file at school
- Demonstrates correct use/administration
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- Agrees to carry medication or keep in an established location
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- Keeps a second labeled container in the health room
- Will not share medication or equipment with others.

Comments:

School Nurse Signature: _____ Date: _____

Cabarrus County Schools Policy for Over-the-Counter Medication Self-Administered by Students:

When a student self-administers an OTC medication without school staff support, the drug must be sent in the original container with only 1or 2 doses with a written authorization signed by the parent and attached to the container. The authorization must also include the date, time and amount of medication to be self-administered by the student.

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