Union County Vocational Technical Schools Field Trip Permission Slip

Please PRINT all information neatly.

Please circle the appropriate school:

☐ AAHS ☐ AIT ☐ APA ☐ UCMHS ☐ UCTECH ☐ ADULT ED

is/are planning a trip to WOODLOCH RESORT in HAWLEY, PA on MAY 24, 2013.

We need your permission in order for your child to participate. The cost will be $65.00.

Approximate time of departure from school: 8:30 AM am/pm

Approximate time of return to school: 7:00 PM am/pm

If the return time is after 2:50pm and a student will be picked up by someone other than his/her parent / guardian or a student will be driving him/herself home, those details must be explained by the parent on the signed permission slip below.

Student should be aware that he/she is representing the school on this trip and should dress neatly and act in a professional manner. Also be aware that overnight field trips require additional safety precautions to be explained by the faculty.

Note: Medications cannot be administered on field trips. If your child has a medical condition that requires medication, please contact the teacher overseeing the trip for a Self Administration of Medication Form, which your doctor must complete and sign. Completed forms must be returned to the school nurse via the overseeing teacher with the permission slip. All medications, prescription or non-prescription, must be in the original labeled container. Only the number of doses required for the length of the field trip should be included.

*Please complete and return the bottom half of this form to the appropriate teacher by APRIL 30, 2013 with the appropriate payment in cash or check made payable to Union County Vocational Technical Schools (UVCTS).

_________________________ has my permission to leave the Union County Vocational Technical School campus for the field trip on MAY 24 to WOODLOCH RESORT and I will not hold anyone in the Union County Vocational Schools liable or responsible for any personal injury, accident or any other problem that might occur.

_________________________ _______________

*Parent/Guardian Signature Date

Emergency contact name & number on day of the Field Trip

*Name: _________________________ phone number: _______________

UNION COUNTY VOCATIONAL-TECHNICAL SCHOOLS
1776 Raritan Road, Scotch Plains, New Jersey 07076-2997
(908) 889-UCVT FAX (908) 889-4336

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

BOTH SIDES OF THIS FORM MUST BE COMPLETED

Asthma Inhalers ________ Allergic Reaction Kit ________ Other ________

STUDENT'S NAME ____

DATE OF BIRTH __________________________ Vo-Tech _______ MHS _______

To be completed by physician: (Please print)

I am requesting that the above named student who has a potentially life-threatening illness be allowed to carry and self-administer the following medications:

Diagnosis for which medication given: ________________________________

Name of medication: ____

Prescribed dosage and time to be taken: ______________________________
If DAILY, at what time: ______________________________________

If "WHEN NEEDED", describe indications: ______________________________

How soon can it be repeated? ____________________________________

Possible side effects and/or special precautions to be taken: ________________

____

Length of time this medication is prescribed: ___________________________

Conditions under which self-administration will take place:
_____ Independently: *Student has been trained and is proficient in self-administering medication and is aware that he/she may not share the medication with anyone else.*
_____ Under supervision of school nurse.

Medication should be:
_____ Stored in the Nurse's office or designated area
_____ In the possession of the student

______________________________ ______________________________
Physician's name (stamp) Physician's signature

______________________________ ______________________________
Date Date

BOTH SIDES OF THIS FORM MUST BE COMPLETED

To be completed by parent: I give my permission for my child to carry and self-administer the medication described above while on school property or off school property at an approved school event. I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician.

The medication is to be provided by me in the original labeled container. A duplicate of this medication is to be sent and kept in the nurse's office. To my knowledge, my child is not allergic to this medication.

I hereby release and hold harmless the Board, its agents, servants and employees from any and all liability for injuries or other damages which may result to the student, his/her servants and representatives from administration of the medication.

______________________________ ________________________
Parent/Guardian's Signature Date

* *

MEDICATION CONTRACT

______________________________ ________________________
Name of Medication Date

I understand that I will use this medication as directed by my physician. I should have the medication readily accessible. I will be responsible and discreet in using it.

I have been instructed how to self-administer this medication and understand the side effects and effects of improper use. The medication must be carried in the original labeled pharmacy container and may not be shred with anyone else. After each use, I will notify the school nurse.

I understand that if I so not abide by the regulations, I may forfeit my right to carry and self-administer this medication. I understand that this contract is to be renewed annually at the beginning of the school year.

____
Student

____
Parent