Cresskill Middle School

Student Permission Form – 8th Grade Washington Trip

June 7th, 8th, & 9th 2017

Keeping in mind that this is an official school function, we the undersigned, hereby agree to the following:

1. Meet all time commitments
2. Follow directions
3. Obey all hotel rules
4. Respect the right and property of others
5. Follow appropriate dress codes

The following actions will not be tolerated:

1. The possession of tobacco, alcoholic beverages, or any illegal substance
2. The defiance of direction from administrators, teachers or chaperones
3. Students leaving rooms after evening curfew

Students participating in any of the above actions will be dealt with in an immediate and forthright matter, i.e.

1. Parents will be contacted
2. Early termination of trip – student picked up by parent(s)/guardian(s) or sent home by bus or train at parent(s)/guardian(s) expense
3. Detention and/or suspension upon return to school

_____ Date_____

Signature of student

_____ Date_____

Signature of parent/guardian

Cresskill Middle School/High School
Field Trip Medical Information

Dear Parents/Guardians:

Please complete the following information for your child and provide a signature at the bottom.

Student Information

Student Name_____

Street Address_____

City (if other than Cresskill)_____

Birth Date_____ Grade_____

Parental/Guardian Information

Mother's Name_____ Home Phone_____

Cell Phone_____

Father's Name_____ Home Phone_____

Cell Phone_____

Alternate Contact

Name_____

Relationship_____ Home Phone_____

Cell Phone_____

Present Medical Information

Is your child allergic to bee stings, food and/or medications?

If yes, please list:_____

_____

_____

Is an Epi-Pen required? _____

Usual Treatments: _____

Please mark NONE if there are no known allergies.

Does your child have Asthma? _____

If yes, does he/she use an inhaler? _____

If your child may self-administer his/her inhaler the "Self-Administration of Medication in School/Field Trips" must be completed and signed by your physician.

List any special health/medical/emotional conditions that an attending medical person should be aware of i.e. heart murmurs, anxiety, etc. Write NONE if there are no conditions.

_____

_____

_____

Presently on prescription medication? List all. If you child requires medication to be given on this trip, "Physician and Parent Request for the Administration of Medicine" must be filled out and signed by your physician and the medication must be given to the nurse prior to the trip and the medication MUST be in its original vial.

_____

_____

If no prescription medications are being given write NONE.

Additional Medical History. Write NONE if there is no additional history/concerns to be added.

_____

_____

_____

If you have answered YES to any of the above questions, contact Ms. Santoro RN, CMS/CSH Nurse at 201-227-7791 ext. 1010.

Date of last Tetanus Booster _____

Consent for Treatment in a Medical Emergency

In the event of a medical emergency, the procedure on this trip will be to call the parent, time permitting, before taking a student to a doctor or hospital. When a parent/Guardian/Designee cannot be reached, the following permission will allow prompt attention.

In the event of an emergency, I acknowledge that school personnel shall attend to the immediate safety of my child prior to my notification.

I give permission for the school trip leader, or designee to sign any consent which may be necessary to allow hospital/licensed personnel to examine my child and perform emergency procedures/treatments.

In providing this consent, I acknowledge that the Cresskill Public Schools are not in any way responsible and shall incur no liability for the actions of the hospital, ambulance, and/or medical personnel and as such I indemnify, hold harmless, and waive any right of legal action against the Cresskill Public School for the action of said personnel.

Parent's Name (please print)_____

Parent's Signature _____

Date _____

CRESSKILL PUBLIC SCHOOLS

PHYSICIAN AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION

PHYSICIAN'S REQUEST

To protect the health of_____, it will be necessary for him/her to have medication during school hours.

MEDICATION_____ DOSAGE_____

TIME and/or SPECIAL CIRCUMSTANCES_____

MEDICATION_____ DOSAGE_____

TIME and/or SPECIAL CIRCUMSTANCES_____

POSSIBLE SIDE EFFECTS_____

PHYSICIAN NAME (please print)_____

PHYSICIAN SIGNATURE_____DATE_____

PARENTAL/GUARDIAN REQUEST

I hereby request that my child_____, who attends Cresskill School, be administered medication during school hours as prescribed by our family physician.

I shall provide the prescribed medication in the original container with a pharmaceutical label indicating name of student, name of prescription, dosage, time, physician's name and date prescription was issued.

PARENT/GUARDIAN NAME (please print)_____

PARENT/GUARDIAN SIGNATURE _____

SCHOOL PHYSICIAN/NURSE (please print)_____

SCHOOL PHYSICIAN/NURSE SIGNATURE_____

CRESSKILL PUBLIC SCHOOLS

Self-Administration of Medication in School/Field Trips

Date_____ Student's Name_____

Date of Birth_____ Weight_____

Medication_____

Dose_____

Route_____

Time_____

Diagnosis/Reason for Medication_____

Possible Side Effects_____

Any circumstances when medication should not be given:_____

THIS STUDENT MAY CARRY AND SELF-ADMINISTER THIS MEDICATION AND HAS BEEN INSTRUCTED ON HOW TO DO SO.

Physician's Signature_____

Physician's Name_____
Address_____
Phone_____

The Physician must complete this for ANY medication.

PARENTAL AUTHORIZATION

I give permission for my child to carry and self-administer this medication according to my physician's instructions. I also verify that I/we have instructed our child in proper use and self-administration of the above medication and that he/she has demonstrated that he/she is capable of safe and correct self-administration of the above medication. I will notify the school immediately if my child's health status changes or there is a change or cancellation of the medication. The medication is to be provided by me in the original labeled container. To my knowledge, my child is not allergic to this medication. I hereby relieve the Board of Education and its employees of all liability which may result from administration of this medication to my child.

Parental Signature_____ Date_____