Omak High School

P.O. Box 833 – 20 S. Cedar
Omak, WA 98841
Phone (509) 826-5150 / Fax (509) 826-8515

OHS FIELD TRIP/SCHOOL ACTIVITY PERMISSION FORM

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.

_____
(Signature of Instructor)

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

_____
(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, (Current authorized staff members are the School Nurse, Kristen Lester, and OHS Para Educator, Cozette Buzzard). 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

_____ _____
(Signature of Parent/Guardian) (Contact phone number)

TEACHERS/ADVISORS*: A copy of this completed/signed permission form & a list of students going on the trip needs to be given to the Attendance Office prior to the day of the trip – also the teacher keeps a copy on hand to take on the field trip.*

Omak School District No. 19

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication	Dosage	Methods of Administration	Time of Day To Be Taken

Diagnosis or reason for medication: _____

If given PRN, specify the length of time between doses: _____

Inhalers: _____
Indicate if student carry on his/her person

Student is capable of self-administration of medication _____ Yes _____ No

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above-named student be administered the above identified oral medication in accordance with the instructions indicated above from _____ (date) to _____ (date) (not to exceed current school year) as there exists a valid health reason which make administration of the medication advisable during school hours.

_____ _____
Date of Signature Licensed Health Professional

_____ _____
Telephone Number Name (Print or type)

Please note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the LHP's instructions for the period from _____ to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication is a timely manner.

Permission to carry inhaler _____ Yes _____ No

Permission to self-administer medication _____ Yes _____ No

_____ _____
Date of Signature Parent/Guardian Signature

Telephone Number: _____ (home) _____ (work)