

FRIENDS ACADEMY

Permission Form for Junior Trip to Washington, D.C.

November 22-24, 2015

Permission to Participate

My child _____ may participate in the Friends Academy Trip to Washington, D.C. I permit her/him to travel by bus/van until his/her return to Friends Academy upon completion of the trip. I understand that participation in this trip is voluntary and that I am under no obligation to complete this agreement. While events and trips have an educational purpose attendance is considered a privilege not a right. The school reserves the right to prohibit a student from attending a trip or event based on their academic or behavioral standing/history. In most cases students on disciplinary probation or warning will be excluded from trips.

Student Behavior and Discipline

I acknowledge that I/my child must strictly adhere to Friends Academy's Fundamental Standards of behavior as described in the Student and Parent Handbook. Any student who chooses to violate the standards of behavior and/or directions of the trip chaperones places her/himself at risk of sitting out of activities (with supervision), or in an extreme case, being sent home at his or her parents/guardians expense. Friends Academy's drug and alcohol policy applies to all trips and events, for traveling students and supervisors. The school will handle all discipline cases in accordance with the policies and procedures described in the Student and Parent Handbook. I therefore agree to abide by the rules, cooperate with the chaperones, and contribute to the well being of the group and its members.

Student Health and Medication

I acknowledge that all appropriate health and medical forms have been completed in their entirety. All medications must be in the original pharmacy container and placed in a zip-lock bag marked with my child's name and administration instructions from the physician. Any student wishing to self-administer medication must demonstrate parental and physician authorization via the Medication Permission Request Form. Those who have need of an inhaler or Epi-Pen will be expected to carry this on their person for the duration of the trip. The school nurse will instruct all chaperones on how to assist with proper use. Any student without authorization to self-administer must hand over medications before departure. A trip leader will collect and administer medications for the duration of the trip. While I understand that the school nurse alerts all chaperones to specific health needs, I may also provide updates on any health concerns that I deem appropriate.

Signature of Participant: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

FRIENDS ACADEMY

Hold Harmless Agreement and Release

I understand and recognize that I am responsible for my own well-being and the well being of the other participants. I declare that I recognize that it is in my best interest, as well as that of the other participants, to follow the suggestions, guidelines, and/or rules of the trip and its activities as outlined by the school handbook and the chaperones. Furthermore, my participation in this trip is entirely voluntary.

I fully understand and appreciate the potential dangers, hazards and or risks, directly and or indirectly inherent in participating in this trip, which could also include the loss of life, serious loss of limb, or loss of Property.

I am aware that all travel and particularly travel abroad which may at times be unsupervised can be a dangerous activity involving risks of serious injury and even death. I understand that although the Teacher at the School intends to lead the Trip, and that although local guides (IF USED) and a representative of the School will also chaperone the Trip, my child will be unsupervised at times during his/her participation in the Trip. I agree that the School is not an insurer of the health or safety of my child and does not assume responsibility for spontaneous and unforeseen events, which may occur during his/her participation in the Trip.

I understand that any school personnel or agents also participating in this activity are not necessarily medically trained to care for any physical or medical problems that occur during this activity. I further understand that the School does not carry medical or liability insurance for me while I am participating in this activity. By placing my signature below, I acknowledge to the School that I have adequate medical and hospitalization insurance for any injuries that I may incur as a result of participating in this activity.

NOW, THEREFORE, in consideration for being allowed to participate in this activity, I agree to hold the supervisor(s) and coordinator(s) of this activity, Friends Academy, its Board of Trustees, agents, officers, and employees harmless for any and all direct, indirect, special or consequential damages, or costs, legal and otherwise, which I may incur as a result of my participation in this activity(ies), even if due to the negligence of Friends Academy or any person serving in the above-identified capacities.

I have read the above terms of this Agreement/Release, and I understand and voluntarily agree to the Terms and Conditions. This Agreement/Release shall be binding upon the heirs, administrators, executors, and assigns of the undersigned.

Signature of Participant: _____ Date: _____

As a parent/guardian of the above-named minor, I have read the above terms of this Agreement, and I understand and agree to the terms and conditions stated herein. This Agreement/Release shall be binding upon the heirs, administrators, executors, and assigns of the undersigned. I further agree to indemnify Friends Academy, its agents, officers and employees against any action brought against Friends Academy by the above-named Participant, including but not limited to an action brought by him or her upon reaching the age of majority. I warrant that I am authorized to execute this Agreement and Release on behalf of the above-named minor.

Signature of Parent/Guardian: _____ Date: _____

Address of Parent/Guardian: _____

FRIENDS ACADEMY

Authorization to Consent to Health Care for Minor (Optional)

I, _____, of _____, am the custodial parent having legal custody of _____, a minor child, age _____, born _____. I authorize Friends Academy, adults in whose care the minor children have been entrusted to act as agents for myself in my absence or incapacitation, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (1) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (2) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agents named herein.

_____ **Date** _____ **Custodial Parent**

STATE OF NEW YORK
COUNTY OF NASSAU

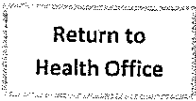
On this ____ day of _____, 20____, _____ personally appeared before me, and known to me to be the person described in and who executed the foregoing instrument and she/he acknowledges that she/he executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

Notary Public
My Commission Expires: _____
(OFFICIAL SEAL)

Health Insurance Information

Insurance Carrier: _____

Group/Policy Number: _____



Medication Permission Request Form

Name of Student: _____ Date of Birth: _____
 School: _____

To Be Completed By Licensed Health Care Prescriber/MD

Medication Name	Dose	Route	Time at School	Prescriber/MD <input checked="" type="checkbox"/> applicable boxes
				Medication necessary for Field Trips: Yes <input type="checkbox"/> No <input type="checkbox"/> May Self Admin-Self Carry (for inhalers, Epi Pen or insulin). Yes <input type="checkbox"/> No <input type="checkbox"/>
				Medication necessary for Field Trips: Yes <input type="checkbox"/> No <input type="checkbox"/> May Self Admin-Self Carry (for inhalers, Epi Pen or insulin). Yes <input type="checkbox"/> No <input type="checkbox"/>
				Medication necessary for Field Trips: Yes <input type="checkbox"/> No <input type="checkbox"/> May Self Admin-Self Carry (for inhalers, Epi Pen or insulin). Yes <input type="checkbox"/> No <input type="checkbox"/>

Licensed Health Care Prescriber /MD please refer to the following description for insulin, Epi Pen or inhalers

Self-Administer/ Self-Carry	I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.
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Related Diagnosis: _____ ICD code: _____

The following side effects are common: _____

The following side effects should be reported to me: _____

Additional comments: _____

Name and Title of Licensed Health Care Prescriber (Please Print) _____

Prescriber's Signature _____ Date _____ Phone _____

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it. I understand that medication normally given at school during a delayed opening or early dismissal will need to be given at home.

Parent/Guardian Signature _____ Date _____ Phone _____

Self-Administer/Self Carry (for inhalers, Epi Pen or insulin)

Parent permission and provider consent is required for students to self-administer and self-carry medication (inhalers, Epi Pen or insulin). Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature _____ Date _____ Phone _____