Fairfax County PUBLIC SCHOOLS
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PARENTAL AUTHORIZATION AND ACKNOWLEDGEMENT OF RISK FOR FIELD TRIP

(This form and an attached itinerary description are required for all field trips.)

IMPORTANT DIRECTIONS: (1) Use one form per trip, (2) Complete the school portion (top half) of form, (3) Duplicate one form per student, and (4) Send a copy home for parent and student signatures.

TO BE COMPLETED BY THE SCHOOL

Date(s) of Trip	Destination
Purpose	

FCPS stock medications, to include (Epinephrine, Albuterol, and Naloxone) will not be provided on this field trip.

SUPERVISION (Check one.)

Students will be directly supervised by adults on this trip at all times

Students will be directly supervised by adults on this trip with the following exceptions:

TRANSPORTATION BEING PROVIDED (Check all that apply.)

Walking | School Bus | Commercial Carrier | Personal Vehicle

Leased Vehicle | County Vehicle | None

DRIVERS OF PRIVATE OR LEASED VEHICLES (Check all that apply.)

Student | Parent | Teacher or Staff Member | Other Adult

VEHICLE TYPE (Check all that apply.)

Car | Van (10 passenger or less) | SUV | Other _____ *(Specify)*

RISK RELATED (Check all that apply.)

Swimming Pool | Amusement or Theme Park | Beach or Ocean | Other _____ *(List activity)*

TO BE COMPLETED AT HOME

Pupil Agreement

While participating in this trip, I will accept responsibility for maintaining good conduct and appearance, and I will follow directions at all times.

_____ _____

Signature of Student | Date

PARENTAL AUTHORIZATION AND ACKNOWLEDGEMENT OF RISKS

I understand that participation in this trip is voluntary, that it is not required, and that it exposes my child to some risk(s). I also understand that the trip may include amusement activities and that participation in any amusement activities will expose my child to some risk of injury or even death. I have read and understand the itinerary and authorize my child to participate in the planned components of the trip to the extent indicated by my signature below. I also understand that participation in the trip will involve activities off school property; therefore, neither the Fairfax County School Board, or its employees and volunteers, will have any responsibility for the condition or use of any nonschool property.

PARENT PERMISSION (Check all that apply.)

Participation in all aspects of this trip.

Participation in all aspects of this trip, except the amusement and theme park activities.

Participation in all aspects of this trip, except the water-related activities.

Other _____

I give permission for _____ to participate in this field trip.

_____ _____

Signature of Parent | Date

IMPORTANT NOTICE Fairfax County Public Schools (FCPS) cannot be responsible for reimbursements to parents or students of money submitted as advance payment (e.g., for Broadway shows, transportation, or hotels) for any trip **that FCPS cancels. It is strongly recommended that you personally review any tour company's or commercial carrier's contract, including its stated refund policies, BEFORE your child signs up or pays for the trip.**

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IMPORTANT

PARENT AND/OR GUARDIAN SIGNATURE SHEET

Please log on to your SIS ParentVue account and sign to acknowledge review of this document OR sign and return this form to your child's school by September 30, 2024.

By signing and returning this page, you acknowledge that you have received the *Student Rights & Responsibilities: A Guide for Families* for school year 2024-25. This booklet is required by law and contains the following:

- Acceptable Use Policy for Student Network Access (Appendix A)
- Standards of Conduct for Students Riding School Buses (Appendix B)
- Parent/Guardian Responsibility and Involvement Requirements (Appendix C)
- Compulsory School Attendance (Appendix C)
- Law Regarding Prosecution of Juveniles as Adults (Appendix C)
- Standards of Student Conduct, Interventions, and Consequences in Regulation 2601.38P (Appendix D)

This form will be kept at your child's school.

The undersigned parent or guardian acknowledges receipt of all items listed above.

_____ _____

Parent or Guardian's Signature Date

To enable us to properly record that you have returned this sheet, please carefully print the information below:

_____ _____

Student's Name Student's Grade

_____

Student's Teacher or Counselor

By signing the above statement, parents or guardians shall not be deemed to waive, but to expressly reserve, their rights protected by the constitutions or laws of the United States or the Commonwealth of Virginia, and the parent or guardian shall have the right to express disagreement with a school's or school division's policies or decisions.

Fairfax County
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FIELD TRIP LUGGAGE SEARCH

No student will be allowed to participate in the school activity scheduled for departure on _____ , 20 ___ , unless PART I or PART II is completed and signed by a parent or guardian.

PART I
CONSENT TO SEARCH

I, _____ , give my consent to officials of Fairfax County Public
Print Parent's or Guardian's Name
Schools and their officially designated representatives to search the luggage of my child, _____ , in connection with the school activity scheduled
Print Student's Name
for the above date. Also, I give my consent for any search, deemed advisable, of my child's lodgings while on the trip.

_____ _____
Parent's or Guardian's Signature Date

PART II
CERTIFICATION OF CONTENTS AND DELIVERY OF LUGGAGE

I, _____, certify that I will search and deliver the luggage of my
Print Parent's or Guardian's Name
child, _____ , and it will not contain any illegal or prohibited items.
Print Student's Name
Also, I give my consent for any search, deemed advisable, of my child's lodgings including luggage, while on the trip.

_____ _____
Parent's or Guardian's Signature Date

FS-143 (12/18)

Cash on Delivery "C.O.D." FORM

Engaging in behaviors or activities that violate the FCPS Student Rights and Responsibilities policies may result in a student's dismissal from band field trips. All disciplinary decisions will be made by the Band Director. If a student's behavior results in dismissal from the trip, the parent/guardian will be notified by phone and arrangements made for the student's transportation home.

The 2021-2022 FCPS Student Rights and Responsibilities handbook may be accessed online at https://www.fcps.edu/srr

---

Student Name: _____

Parent/Guardian Name:_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

I understand that FCPS policies and procedures are in effect during all band field trips and that student infractions may result in dismissal from the field trip. I understand that I will be responsible for all transportation expenses for my student in the event of a dismissal.

Preferred mode of COD transportation, if necessary:

_____ Bus _____ Train _____ Plane

Signed:

Parent/Guardian Date

Signed:

Student Date

EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

School Name:	ID No.:	Teacher or Counselor :	Bus # (AM):	Bus # (PM):

☐ Student has medical alert information on file. See page 2 for details.

Student Cell _____

PARENT/GUARDIAN CONTACT INFORMATION

This form is to be completed by the enrolling parent. The enrolling parent is the natural or adoptive parent or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Enrolling Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Self | ☐ Resides with | Language: | E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: | ☐ Resides with | Language: | E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: | ☐ Resides with | Language: | E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: | ☐ Resides with | Language: | E-mail:

OTHER CONTACT INFORMATION

Please list at least two people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. These people also have your permission to pick your child up from school during the school day.

Name of Person	Relationship	Language	Telephone

* Please remember to sign page 2.

EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

School Name:	ID No.:	Teacher or Counselor:	Bus # (AM):	Bus # (PM):

Siblings attending the same school (complete if applicable).

Name(s): _____

Name(s): _____

Primary Internet access in the home for this student is

☐ Cellular ☐ Broadband ☐ Other ☐ None ☐ Declined

Do you have a device for this student to use that meets their educational needs? ☐ Yes ☐ No ☐ Declined

CURRENT HEALTH CONDITIONS

Below check any current health condition(s) that EMS or an emergency room physician should know about health of your student. **Also complete and submit Health Information form SS/SE-71 if your child has a health condition(s) that require(s) attention during the school day. See below for medical alert information currently on file.**

☐ allergies (be specific)

- ☐ foods _____
- ☐ medicines _____
- ☐ bee sting or insect bite _____
- ☐ other _____

☐ asthma

☐ cancer

☐ diabetes

☐ hearing problems ☐ hearing aid(s)

☐ heart problems (be specific) _____

☐ hemophilia ☐ sickle cell anemia

☐ physical disability (be specific)

_____

☐ respiratory (be specific)

_____

☐ seizures

☐ vision problems (be specific) _____

- ☐ glasses ☐ contacts

☐ other (be specific)

_____

_____

List all medications and dosages your child receives on a continual basis:

_____

_____

_____

MEDICAL ALERT INFORMATION ON FILE

PHYSICIAN INFORMATION

My child's medical care is provided by: _____ _____
(name of doctor, clinic, or HMO) (telephone)

Does your child have health insurance? ☐ Yes ☐ No

If yes, medical coverage is provided by: _____ _____
(health insurance company, assistance program, HMO, etc.) (telephone)

First aid and emergency treatment will be provided to students in accordance with the current version of FCPS Regulation 2102 or in accordance with the student's individualized health plan.

ENROLLING PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____

Parent Information About the Emergency Care Information Form

What is the Emergency Care Information form used for?
School staff rely on the Emergency Care Information form to provide them with information needed to (1) contact a parent or other responsible adult in the event of an emergency concerning the student; (2) assist school staff or emergency medical services in the event the student requires medical services for illness or injury; (3) respond to requests to release of the student during the school day in nonemergency situations.

Who is responsible for completing the Emergency Care Information form?
This form should be completed by the enrolling parent. The enrolling parent is the natural parent, adoptive or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Who else should be listed in the Parent/Guardian Contact Information section of the form?
The Parent/Guardian Contact Information section has space for a student's other natural or adoptive parent or legal guardian to be listed. A parent's contact information should be listed in the second box if the parent shares legal custody of the child with the enrolling parent. School staff will share information about the student and will release the student to a parent who has legal custody of the child. A stepparent that resides with the child may also be listed in the Parent/ Guardian Contact Information section of the form.

Who should be listed in the Other Contact Information section of the form?
It is very important that school staff have contact information for at least two responsible adults who can be contacted in the event of an emergency when the parents cannot be reached. Other adult family members or friends should be listed in the Other Contact Information section of the form.

Please also note that school staff will allow any person you list on this form in the Other Contact Information section to pick up the child from school during the school day in both emergency and nonemergency situations.

In the event of an emergency, who will the school notify?
In the event of an emergency, school staff members will attempt to contact the enrolling parent first. If the enrolling parent cannot be reached, school staff will then attempt to reach the parent/guardian, if any. If neither the enrolling nor other parent/guardian listed can be reached, school staff shall contact the people listed in the Other Contact Information section on the Emergency Care Information form. Once a parent or designated contact is reached, staff will provide him or her with information about the student and the emergency situation and will release the student to him or her, as appropriate.

A noncustodial parent may be provided with information about the child, but staff will not release the student to him or her without the written consent of the custodial parent (Regulation 2240, III.B, and IV.F).

What should I do if I need to update the information on this form?
It is extremely important that school staff have the most up to date and accurate information about your child. The enrolling parent may update information on this form at any time by either contacting the school or accessing weCare@school in the FCPS 24-7 website (fcps.blackboard.com).

Where can I find more information about FCPS's procedures regarding the emergency care information form and first aid and emergency treatment for students?
Please refer to FCPS Regulation 2240, Parent Participation and Decision-making and FCPS Regulation 2102, First Aid, Emergency Treatment, and Administration of Medication for Students for additional information.

How do I change the phone number used for attendance and non-emergency calls?
Changes to the phone number used for attendance and non-emergency calls can only be made by contacting your child's school directly and specifying that you wish to have the student home phone number changed.

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HEALTH INFORMATION

Complete this form every school year to inform us about your student's existing and new health conditions that affect your student's school day

This form is necessary to inform the Public Health Nurse (PHN) of your child's health status and to plan for health needs that may impact his/her school day. Information is only shared with required school staff, as needed. Information provided on this form is protected by the Family Educational Rights and Privacy Act (FERPA) as part of the student's education record and is securely stored in the health room. De-identified, aggregate health data is also used by Fairfax County Public Schools (FCPS) and the Fairfax County Health Department (FCHD) to complete required public health reporting to the Virginia Department of Education and to monitor health needs in the school community. For any changes to your student's health condition during the school year or questions regarding this form, please contact the PHN through the health room at your child's school.

Section A: Demographics:

Student Name: Last	First	Middle	Date of Birth

School Year	School Name	Grade	Teacher/Counselor	Gender: ☐ Male ☐ Female ☐ Non-Binary

Parent/Legal Guardian Name	Home Phone Number	Cell Phone Number	Work Phone Number
Parent/Legal Guardian Name	Home Phone Number	Cell Phone Number	Work Phone Number

Section B: Severe or Life-Threatening Health Conditions:

Condition	Check if Yes	Comment
Severe Allergies/Anaphylaxis	☐	☐ Foods: _____ ☐ Insect Sting: _____ ☐ Latex Epinephrine prescribed? ☐ Yes ☐ No Epinephrine injection previously given? ☐ Yes ☐ No If yes, date of injection: _____
Asthma	☐	Triggers: ☐ Exercise ☐ Environmental ☐ Upper Respiratory Infection ☐ Other: _____ Inhaler prescribed? ☐ Yes ☐ No Nebulizer Treatment prescribed? ☐ Yes ☐ No Number of Emergency Room (ER) Visits in the last calendar year: ____
Diabetes	☐	☐ Type 1 ☐ Type 2 Diagnosis Date: _____ Name of emergency medication: _____ Glucose Monitoring: ☐ Glucometer ☐ CGM Insulin Administration: ☐ Syringe ☐ Pen ☐ Pump
Seizures	☐	Type of Seizure: _____ Date of last seizure: _____ Emergency Medication Needed at school? ☐ Yes ☐ No VNS implanted? ☐ Yes ☐ No

Section C: Current Physical Health Conditions:

Condition	Check if Yes	Comment (Please provide details)
Height/Weight		Height: ____ ft. ____ in. Weight: _____ lbs.
Allergies (non-life threatening)	☐	
Blood Disorder	☐	
Cancer	☐	Currently Immunocompromised ☐ Yes ☐ No
Cystic Fibrosis	☐	
Dental/Oral Health Condition	☐	
Ear, Nose & Throat Conditions	☐	Please specify:
Endocrine Disorder (other than Diabetes)	☐	
Food Intolerance	☐	Foods: _____ Gastrointestinal/Digestive Distress ☐ Yes ☐ No
Food/Dietary Preference	☐	
Gastrointestinal/Stomach/Bowel	☐	
Hearing Conditions	☐	
Heart/Cardiovascular	☐	
Kidney/Urinary Tract Disorders	☐	
Headache/Migraines	☐	
Lung Disease (other than Asthma)	☐	
Mobility Impairment	☐	

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HEALTH INFORMATION

Complete this form every school year to inform us about your student's existing and new health conditions that affect your student's school day

Last Name _____ **First Name** _____ **Date of Birth** _____

Section D: Current Health Conditions, Continued:

Condition	Check if Yes	Comment (Please provide details)
Muscle/Bone/Joint/Arthritis	☐	Please specify:
Neurological (other than seizures)	☐	☐ Brain Injury/Concussion/Date Diagnosed: _____ ☐ Cerebral Palsy ☐ Other: _____
Skin Condition	☐	☐ Eczema ☐ Other: _____
Vision Conditions	☐	☐ Contacts/Glasses ☐ Non-Correctable ☐ Other: _____
Other Health Conditions	☐	☐ Autism ☐ Down Syndrome ☐ Other: _____
Emotional/Mental Health Conditions:		
ADD/ADHD	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Anxiety	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Depression	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Eating Disorder	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Other: _____	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No

Section E: Health Procedures:

The Fairfax County Health Department provides referral information to community medical resources providing free physical examinations. Visit https://www.fairfaxcounty.gov/health/clinics.

If your child has a health condition, does your child require any health procedures or need any special equipment during the school days?

☐ **Yes** ☐ **No** **If you answered Yes, please describe:** _____

Section F: List all medications and dosages your child receives on a regular basis and indicate which ones to be taken at school:

_____

_____

_____

Parent or guardian is responsible for providing the school with any medication, special food, equipment that the student may require during the day. Medication, Procedure Authorization, and Physical Education (PE) forms may be found at https://www.fcps.edu/registration/forms or obtained in the school Health Room.

Parental Consent: I agree to allow my child's healthcare provider(s) to discuss information contained in this form with FCPS staff and School Public Health Nurse. ☐ Yes ☐ No

_____ Healthcare Provider Name

_____ Healthcare Provider Phone Number

_____ Parent/Guardian Name (Print or Type)

_____ Parent/Guardian Signature

_____ Date

Public Health Nurse Use Only Below This Line

☐ HIF Reviewed ☐ Follow Protocol (SH Care Emerg.-Temp. Care Guidelines) ☐ Health Condition List

☐ Mental Health Condition List ☐ Action Plan/Health Plan or Procedure

Notes: _____

_____ Public Health Nurse Name

_____ Public Health Nurse Signature

_____ Date

Oakton High School Bands

Over-the-Counter Medications

Student's Name: _____

I give permission for my child to take (use) any of the over-the-counter medications checked below for simple headaches, cramps, upset stomach, sore throat, coughs, minor injuries, or tooth pain. These medications will be given as needed, not on a regular basis. Please check all that apply:

____ Acetaminophen (Tylenol)

____ Pepto-Bismol

____ Benadryl

____ Dramamine

____ Insect Repellant

____ Hydrocortisone Cream

____ Ibuprofen (Advil/Motrin)

____ Antibiotic Ointment

____ Aloe Vera (Sunburn Relief)

____ Imodium

____ Sudafed

____ Sunscreen

____ All of the above

_____ _____

Parent/Guardian Signature Date

This permission form is only for over-the-counter medications. The regular FCPS form is still required for prescription medications. If other over-the-counter medications are required by the student during the marching season or on trips, the medications must be provided by the parent/guardian with specific dosage instructions, AND a medical authorization form must be sent in, SIGNED by the parent, along with the medication.

Oakton High School Bands

Medical Disclosure to Parent Chaperones

Only FCPS employees will have access to the FCPS medical forms submitted in this packet, and the forms will only be accessed in the event of an emergency. With this form, you provide important information to parents who chaperone your child on band trips.

Student's Name: _____

Allergies to medication: _____

Allergies to food: _____

Other allergies: _____

Pre-existing medical conditions: _____

_____

_____ _____

Parent/Guardian Signature Date

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MEDICATION AUTHORIZATION

Release and Indemnification Agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE **PLEASE USE A SEPARATE FORM FOR EACH MEDICATION**

PART I PARENT OR GUARDIAN TO COMPLETE

I hereby authorize Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless FCPS, FCHD, SACC, and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided FCPS, FCHD, and SACC staff members comply with the licensed prescriber, parent or guardian orders set forth in accordance with the provision of Part II below. **I have read the procedures outlined on the back of this form and assume responsibility as required.**

Has the student taken this medication before? ☐ Yes ☐ No (If no, the first full dose must be given at home to ensure that the student does not have a negative reaction.)
First dose was given: Date _____ Time _____

Student Name: Last	First	Middle

Date of Birth	School Name	School Year	Grade

No School Board employee, public health nurse, or school health aide shall administer medication or treatment, as an exception under School Board policy, unless the principal or his or her designee has personally reviewed all the required clearances. I give permission to contact the below named licensed prescriber to clarify information provided on the order should the need arise.

_____ _____ _____
Parent or Guardian Signature Daytime Telephone Date

PART II PARENT OR GUARDIAN TO COMPLETE AND SIGN FOR OVER-THE-COUNTER MEDICATION PER MANUFACTURER'S RECOMMENDATION FOR RELIEF OF SYMPTOMS FOR HEADACHE, MUSCLE ACHE, ORTHODONTIC PAIN, OR MENSTRUAL CRAMPS AND FOR ANTIBIOTIC AND ANTIVIRAL MEDICATION FOR UP TO TEN CONSECUTIVE SCHOOL DAYS. LICENSED PRESCRIBER MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS.

The Fairfax County Health Department and Fairfax County Public Schools discourage the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and overnight field trips and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

Diagnosis

Medication	Route (Oral, Injection, Inhalation, Topical, Buccal, Rectal, etc.)

If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.

Dosage to be given at school or SACC, (e.g. mg, ml, or cc)	Time(s) or interval between times to be given

Effective Date: _____
☐ Current School Year **OR** ☐ From _____ To _____

If the student is taking more than one medication for the same symptom(s), list sequence in which medications are to be taken:
_____

_____ _____ _____ _____
Licensed Prescriber Name (Print or Type) Licensed Prescriber Signature Telephone or Fax Date

_____ _____ _____ _____
Parent or Guardian Name (Print or Type) Parent or Guardian Signature Telephone Date
(Not required if licensed prescriber signs)

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate:

☐ Parts I & II above are complete including signatures. (It is acceptable if all items in Part II are written on the licensed prescriber's stationery or a prescription pad.)
☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be PICKED UP by the parent or guardian.
(Within one week after expiration of this authorization or on the last day of school.)

_____ _____
Principal or Principal Designee Signature Date

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

PARENT/GUARDIAN INFORMATION ABOUT MEDICATION PROCEDURES

1. Medications should be taken at home whenever possible so that the student will not lose valuable classroom time or have a shortened lunch period. Any medication taken in school or SACC must have a parent or guardian-signed authorization; some medications also require licensed prescriber's orders. Medication must be kept in the school health room or other school-approved location during the school day. **The parent or guardian must transport medications to and from school, except a high school student may carry an over-the-counter medication to and from the school health room.**

2. No medication will be accepted by school or SACC personnel without receipt of completed and appropriate medication forms. Only a 30-day supply of medication should be brought in to school at a time.

3. A licensed prescriber may use office stationery or a prescription pad in lieu of completing Part II. Include the following information written in lay language with no abbreviations:

   - Name of student
   - Date of birth
   - Reason for medication or diagnosis
   - Name of medication
   - Exact dosage to be taken in school (e.g., mg, ml, or cc)
   - Route of administration
   - Time to take medication and frequency or exact time interval dosage is to be administered
   - Sequence in which the medications should be taken in cases where more than one medication is prescribed
   - If medication is given on an as-needed basis, specify the exact conditions or symptoms when medication is to be taken and the time at which it may be given again. ("Repeat as necessary" is unacceptable.)
   - Duration or effective dates of medication order
   - Licensed prescriber's signature and date

4. All prescription medications, including licensed prescriber's prescription drug samples, **must** be in their original containers and labeled by a licensed prescriber or pharmacist. An over-the-counter medication **must** be in the original container with the name of the medication visible. The parent or guardian must label the original container with the following:

   - Name of student
   - Route of administration
   - Exact dosage to be taken in school (e.g., mg, ml, or cc)
   - Frequency or time interval dosage is to be administered

5. **The first dose of any new medication must be given at home.**

6. The parent or guardian is responsible for submitting a new form to the school and to SACC at the start of the school year and each time there is a change in the dosage or in the time at which medication is to be taken.

7. Medication kept in the school will be stored in a locked area accessible only to authorized personnel.

8. Within one week after expiration of this authorization or on the last day of school, the parent or guardian must pick up any unused portion of the medication. Medications not claimed within that period will be destroyed.

9. The student is to come to the school health room, or to a predetermined location, at the prescribed time to receive medication. Parent or guardian should develop a plan with the student to ensure that the student goes to the school health room at the appropriate time. **Medication can be given no more than one half hour before or after the prescribed time.**

10. The Fairfax County Health Department, Fairfax County Public Schools, and Fairfax County School Age Child Care do not assume responsibility for authorized medication taken independently by the student.

11. In no case may any health, school, or SACC staff member administer any medication outside the framework of the procedures outlined here and/or in FCPS regulations.

12. The parent or guardian must provide FCPS and SACC a supply of medication to be administered during the school day and in SACC.

VIRGINIA PEDIATRIC ASTHMA ACTION PLAN

Child Name:

DOB:

School Year:

Healthcare Provider

Contact Number:

EMERGENCY CONTACT

Name:

Phone:

Relationship:

Additional info:

GREEN ZONE: GO!

- No trouble breathing
- No cough or wheeze
- Sleeps well
- Can play as usual

☐ **Daily Maintenance/Controller**

	Day puffs	Night puffs

☐ Montelukast/Singulair ____ Mg once daily.

Use controller daily, even when I feel fine. Use a spacer if recommended.

For Asthma with exercise add: ____ **puffs (with spacer if needed) 15 minutes prior to exercise:**

____ And ☐ Ipratropium ☐ Only if needed

YELLOW ZONE: Caution!

- Cough, wheeze, chest tightness
- Waking at night due to asthma
- Problems sleeping, working, or playing

Add: quick-relief medicine—to your GREEN ZONE medicines.

First

Your quick reliever medicine(s) is: ____ or ____

Take: ____ puffs or ☐ Nebulizer every – 20 minutes if needed for up to 1 hour. If your symptoms resolve return to GREEN ZONE.

Second

If your symptoms continue or return within a few hours of above treatment, take:

☐ Puffs every 4-6 hours as needed until symptoms resolve.

☐ Continue every 4-6 hours daily for ____ days.

☐ Add: ____

Call Healthcare Provider if you need quick-relief medicine for more than 24 hours or if quick-relief medicine does not work.

You should not use more than 8 puffs for ages 4-11 or 12 puffs ICS/formoterol for ages 12+ a day.

RED ZONE: DANGER!

- Can't talk, eat, walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Nonstop cough
- Ribs show

CALL 911 Now/Go to the Emergency Department!

Continue CONTROL & RELIEVER Medicines every 15 minutes for 3 treatments total – while waiting for help.

Take: ____ ☐ 2 puffs ☐ 4 puffs ☐ 6 puffs or ☐ nebulizer

I approve and give permission for school personnel to follow this asthma management plan of care for my child, contact my child's healthcare provider when needed, and administer medication per the healthcare providers orders. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. With HCP authorization & parental consent, the inhaler will be located: ☐ in clinic or ☐ with student (self-carry).

Parent/Guardian signature ____ Date ____

School Nurse/Staff Signature ____ Date ____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

☐ Student may carry and self-administer inhaler at school.

☐ Student needs assistance & should not self-carry.

MD/NP/PA signature ____ Date ____

Approved June 2023, Virginia Asthma Action Plan Expert Group convened by the Consortium for Infant and Child Health at Eastern Virginia Medical School.

Updated March 2024

Fairfax County PUBLIC SCHOOLS
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FCPS Authorization for Virginia Asthma Action Plan

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I PARENT OR GUARDIAN TO COMPLETE

I hereby authorize Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless FCPS, FCHD, SACC, and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided FCPS, FCHD, and SACC staff members comply with the health care provider, parent or guardian orders set forth in accordance with the provision below. **I have read the procedures outlined on the back of this form and assume responsibility as required. I am providing a completed Virginia Asthma Action Plan.**

Student Name: Last	First	Middle

Date of Birth	School Name	School Year	Grade

No School Board employee, public health nurse, or school health aide shall administer medication or treatment, as an exception under School Board policy, unless the principal or his or her designee has personally reviewed all the required clearances. I give permission to contact the below named health care provider to clarify information provided on the order should the need arise.

Parent or Guardian Signature _____ Daytime Telephone _____ Date _____

PART II GUIDANCE

GREEN ZONE: GO!

- No actions are needed at school.
- For asthma with exercise, follow GREEN ZONE

YELLOW ZONE: CAUTION!

- Administer prescribed puff(s) of inhaler or nebulizer treatment of **rescue medicine** in **YELLOW ZONE**, call parent/guardian
  - If symptoms worsen at any time, go to **RED ZONE**
  - If symptoms return to **GREEN ZONE** within 20 minutes, student may return to class.
  - If symptoms do NOT return to **GREEN ZONE** within 20 minutes, give second dose of inhaler/nebulizer
- After second dose of inhaler/nebulizer
  - If symptoms return to **GREEN ZONE**, student may return to class
  - If symptoms do not improve in 5-10 minutes, call 911 and go to **RED ZONE**
  - If student returns from classroom with symptoms in **YELLOW ZONE**, go to **RED ZONE**

RED ZONE: DANGER!

- Call EMS/911
- Administer prescribed puff(s) of inhaler or nebulizer treatment of **rescue medicine** in **RED ZONE**
- Contact parent/guardian

REMINDER: If the student has a current Virginia Asthma Action Plan completed by their health care provider but does not have their prescribed albuterol inhaler available, follow the student's plan using the school's supply of undesignated stock albuterol and valved holding chamber.

Complete this Section for Students Who Self-Carry and Self-Administer Inhaler	
The student is authorized by a licensed prescriber to carry and self-administer an inhaler at school, school sponsored activities, on a school bus or other school property. The student is to carry an inhaler during school or SACC hours with the principal's knowledge. The student acknowledges they will be responsible for carrying the inhaler and will follow the licensed prescriber's orders as outlined in the Virginia Asthma Action Plan. (An additional inhaler, to be used as a back-up, may be kept in the school health room or other approved school location.)	Parent/Guardian Signature (Required) _____ Date _____ Student Signature (Required) _____ Date _____

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate:

☐ Part I of the Virginia Asthma Action Plan above is complete including signatures.

☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be PICKED UP by the parent or guardian. (Within one week after expiration of this authorization or on the last day of school.)

Principal or Principal Designee Signature _____ Date _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

PARENT/GUARDIAN INFORMATION ABOUT AUTHORIZATION FOR ASTHMA RESCUE MEDICINE PROCEDURES

1. Asthma rescue medicine may be given in school, at school-sponsored activities, on a school bus or other school property or at SACC only with both licensed prescriber and parent or guardian-signed authorization.

2. The parent or guardian is responsible for obtaining the licensed prescriber's order on the Virginia Asthma Action Plan. The form can be found at: Virginia Asthma Action Plan.

3. The parent or guardian will complete this SS/SE-65 form when they bring their student's own asthma rescue medicine and the completed Virginia Asthma Action Plan to school.

4. A licensed prescriber may NOT use office stationery or a prescription pad in lieu of completing the Virginia Asthma Action Plan.

5. Licensed prescriber samples must be appropriately labeled by the licensed prescriber to include information typically printed on a pharmacy label.

6. The first dose of any new medication must be given at home excluding emergency medications including albuterol.

7. The parent or guardian is responsible for submitting a new form to the school or SACC at the start of the school year and each time there is a change in the dosage or in the time at which medication is to be taken.

8. Asthma rescue medicine must be hand delivered to the school health room by the parent or guardian unless approved for the student to carry during school and SACC hours.

9. Medication kept in the school will be stored in a locked area accessible only to authorized personnel unless approved for the student to carry it during school hours. If a student carries his or her own inhaler, a backup may be kept in the school health room.

10. Within one week after expiration of this authorization or on the last day of school, the parent or guardian must pick up any unused portion of the medication(s) unless the student has been authorized to carry them. Medications not claimed within that period will be destroyed.

11. The Fairfax County Health Department, Fairfax County Public Schools, and Fairfax County School Age Child Care do not assume responsibility for authorized medication taken independently by the student.

12. In no case may any health worker or school or SACC staff member administer any medication outside the framework of the procedures outlined here and/or in FCPS regulation.

13. The parent or guardian must provide a supply of medication to FCPS and SACC for medication required to be administered during the school day and in SACC.

Fairfax County PUBLIC SCHOOLS
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FCPS AUTHORIZATION FOR ANAPHYLAXIS ACTION PLAN

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I PARENT OR GUARDIAN TO COMPLETE

I hereby authorize Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer epinephrine injection(s) as directed by the health care provider (Part II). I agree to release, indemnify, and hold harmless FCPS, FCHD, and SACC and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for administering the injection, provided they follow the health care provider's order (Part II.) I am aware that epinephrine may be administered by trained, unlicensed non-health staff, and I consent to this. I am also aware that unlicensed non-health staff cannot observe for the development of symptoms and are not allowed to wait for the appearance of symptoms before administering epinephrine for students with an authorized health care provider's order. **I understand that emergency medical services (EMS) will always be called when epinephrine is administered, whether or not the student manifests any symptoms of anaphylaxis. I have read the procedures outlined on the back of this form and assume responsibility as required.**

Student Name (Last, First, Middle)

Date of Birth	School Name	School Year	Grade

No School Board employee, public health nurse, or school health aide shall administer medication or treatment, as an exception under School Board policy, unless all the required clearances have been personally reviewed by the principal or his or her designee. I give permission to contact the below named health care provider to clarify information provided on the order should the need arise.

Parent or Guardian Signature _____ Daytime Telephone _____ Date _____

PART II HEALTH CARE PROVIDER TO COMPLETE

Epinephrine is usually administered in FCPS or SACC by unlicensed non-health staff. These persons are trained by the school public health nurse to administer the injection. It should be noted that these staff members are not trained observers. Unlicensed non-health staff cannot observe for the development of symptoms and are not allowed to wait for the appearance of symptoms before administering epinephrine for students with an authorized health care provider's order.

Regardless of whether student is symptomatic, the epinephrine will be given immediately after report of exposure to allergen(s): _____
Indicate specific allergen(s) or unknown
before any other medication.

Route of Exposure: ☐ Ingestion ☐ Skin Contact ☐ Inhalation ☐ Insect sting or bite

OR

If student shows **ANY** of the following severe symptoms:

- Sudden difficult breathing or wheezing
- Hives, generalized flushing, itching, or redness of skin
- Swelling of the throat, lips, tongue, throat tightness/change of voice, difficulty swallowing
- Other _____
- Tingling sensation, itching, or metallic taste in mouth
- Feeling of apprehension, agitation
- Vomiting in combination with any of the previously listed symptoms

Check the appropriate box: (Note: Epinephrine will always be given first before any other medication.)

Check the appropriate premeasured dose of epinephrine by intramuscular injection.

Dose of Epinephrine: ☐ 0.3 mg ☐ 0.15 mg ☐ 0.1 mg

Repeat dose in ☐ 5 minutes ☐ 10 minutes ☐ 15 minutes if EMS has not arrived. (Two premeasured doses will be needed in school.)

Give epinephrine first, followed by oral antihistamine immediately, if ordered: Name of Oral Antihistamine _____ Dose: _____

Check ONE appropriate box:

☐ The student is to carry epinephrine during school hours with the principal's knowledge and CAN use the epinephrine injector/syringe properly in an emergency. Student must notify school staff if they use epinephrine on themselves. One additional dose, to be used as backup, should be kept in health room or other approved school location.

☐ The student is to carry epinephrine during school hours with the principal's knowledge but CANNOT use the epinephrine injector/syringe properly in an emergency. One additional dose, to be used as backup, should be kept in health room or other approved school location.

☐ The epinephrine will be kept in the school health room.

Effective date: ☐ Current School Year **OR** ☐ From _____ To _____

Health Care Provider Name (Print or Type) _____ Health Care Provider Signature _____ Telephone or Fax _____ Date _____

Parent or Guardian Name (Print or Type) (Required if student carries epinephrine) _____ Parent or Guardian Signature _____ Telephone _____ Date _____

Student Signature (Required if student carries epinephrine) _____

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate:

☐ Parts I & II above are complete including signatures.

☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be PICKED UP by the parent or guardian. (Within one week after expiration of this authorization or on the last day of school.)

Principal or Principal Designee Signature _____ Date _____

PART IV SCHOOL PUBLIC HEALTH NURSE TO COMPLETE

Check √ as appropriate:

☐ The above orders have been reviewed.

☐ The student's individual Anaphylaxis Action Plan has been completed on the second page.

School Public Health Nurse Name (Print) _____ School Public Health Nurse Name (Signature) _____ Date _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

SS/SE-64 (4/24)

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

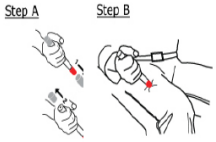
ACTION STEPS FOR EPINEPHRINE ADMINISTRATION (Below sections to be completed by School PHN)

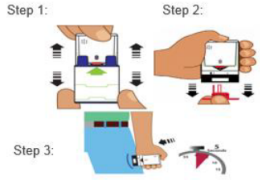
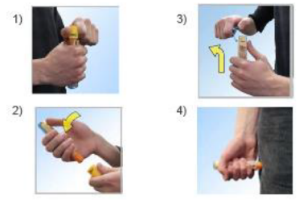
1. **Always use standard precautions.**
2. **Inject Epinephrine immediately. See administration instructions below.** Note the time of the injection.
3. **Call 911.**
4. **Lay person flat with legs elevated, keep warm, or place in position of comfort.**
5. **Give other medication *IF ORDERED*:** _____
6. **If student loses consciousness, check for breathing and begin bystander CPR if needed.**
7. **Notify parent(s) or emergency contacts.**
8. **Write the student's name, time, and date of epinephrine administration on the epinephrine label.**
9. **Repeat epinephrine injection *IF ORDERED* and EMS has not arrived.**
10. **Document epinephrine administration on Medication Chart.**
11. **Send used epinephrine with EMS or parent.**
12. **If student is transported by EMS, provide copy of current Emergency Care Card.**

Location of Epinephrine: ☐ **Health Room** ☐ **Self-Carry** ☐ **Other:** _____

Individual Considerations: _____

School PHN to mark type of epinephrine device received:

☐ EPIPEN® AUTOINJECTOR	☐ GENERIC EPINEPHRINE AUTOINJECTOR
DIRECTIONS 1. Remove EpiPen Auto-Injector from plastic carrying case. 2. Pull off blue safety release cap. 3. Hold leg to stabilize. 4. Place orange tip against mid-outer thigh and firmly push. Press firmly and hold for 3 seconds. 5. Remove and massage the area for 10 seconds.	**DIRECTIONS** 1. Remove the outer case. 2. Remove both end caps (1 and 2). 3. Hold the leg to stabilize. 4. Place rounded tip against mid-outer thigh. 5. Press down hard until needle penetrates. Hold for 10 seconds. 6. Remove and massage the area for 10 seconds. 7. Needle will be exposed; dispose of per training.
	

☐ AUVI-Q® AUTOINJECTOR	☐ TEVA GENERIC AUTOINJECTOR
DIRECTIONS 1. Remove the outer case; voice command automatically activates. 2. Pull off red safety guard. 3. Hold leg to stabilize. 4. Place black end against mid-outer thigh. 5. Press firmly and hold for 2 seconds. 6. Remove and massage the area for 10 seconds.	**DIRECTIONS** 1. There is no outer case for this device. 2. Twist the yellow or green cap in the direction of the "twist arrow" to remove cap. 3. Pull off the blue safety release cap. 4. Hold leg to stabilize. 5. Place orange tip against mid-outer thigh and firmly push until you hear a click. Hold firmly in place for 3 seconds. 6. Remove and massage the area for 10 seconds.
	

PARENT/GUARDIAN INFORMATION ABOUT EPINEPHRINE PROCEDURES

1. Epinephrine may be given in school, during school-sponsored activities, or at SACC only with both health care provider and parent or guardian-signed authorization.
2. This form must be on file in the health room or in another approved location. The parent or guardian is responsible for obtaining the health care provider's order in part II. For a student who attends SACC, a copy of the epinephrine authorization must be on file with SACC.
3. A new authorization must be submitted to the school each school year and whenever there is a change in the dosage or a change in the conditions under which epinephrine is to be injected.
4. Only premeasured doses of epinephrine may be given by FCPS, FCHD, and SACC staff members.
5. Epinephrine for students with authorized health care provider's orders may be administered in FCPS or SACC by trained, unlicensed non-health staff who cannot observe for the development of symptoms and are not allowed to wait for the appearance of symptoms before administering the epinephrine.
6. Medication must be properly labeled by a pharmacist. If health care provider's order includes a repeat of the epinephrine injection, then the parent or guardian must supply the school with two epinephrine injectors/syringes. For a student who carries his or her own epinephrine, the parent or guardian must supply the school with a backup that is stored in the health room or other approved location. Expiration date must be clearly indicated on the pharmacy label or injector/syringe. The parent or guardian must provide replacement epinephrine when notified that the current injector/syringe has expired or has been administered.
7. Epinephrine must be hand-delivered to the school health room by the parent or guardian unless approved for the student to carry during school and SACC hours.
8. Unless the student has been authorized to carry epinephrine, the parent or guardian is to pick up any unused epinephrine within one week after expiration of this authorization or on the last day of school. Epinephrine not claimed within that period shall be destroyed.

Student's Name: _____

Photo Release Opt Out Form

You have the right to choose whether your student's photograph is published or not. The band posts photos on the band's password protected photo sharing site, and typically a photo of the entire band appears on the website's open home page. Student names or other identifying information are not posted with the photographs. If you want to prohibit the publication of photographs of your student in band media, put an X and sign below. **You do not need to return this form if you allow your student's photograph to be published.**

( ) Do not publish photographs of my student

_____ _____

Parent/Guardian Signature Date