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	

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)*

STOCK EPINEPHRINE (Check one) Will be available on this trip | Will not be available on this trip

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 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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Parent and/or Guardian Signature Sheet

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 29, 2023**.**

By signing and returning this page, you acknowledge that you have received the *Student Rights & Responsibilities: A Guide for Families* for school year 2023-24. 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)
- Parental 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 2601.37P (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.

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 2022-2023 FCPS Student Rights and Responsibilities handbook may be accessed online at https://www.fcps.edu/srr

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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

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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)

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 annually to inform us about your student's health condition that affects his or her 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 educational record and is securely stored in the health room. 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. Contact your child's school front office staff and ask to be connected with the health room.

Section A: Demographics

Student Name: Last	First	Middle	Date of Birth

School Year	School Name	Grade	Teacher	Gender: ☐ Male ☐ Female

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: Life Threatening Health Conditions

Does your child have a potentially life threatening health condition to include any of the following?

☐ Diabetes, Type 1 ☐ Seizures requiring rescue medication ☐ Allergy requiring epinephrine ☐ Severe Asthma

Section C: Current Health Conditions

Condition	Check if Yes	Comment
ADD/ADHD		_____ **Provider Diagnosed:** ☐ Yes ☐ No **Under Treatment:** ☐ Yes ☐ No
Allergies		**NOTE: Medication allergies are listed ONLY on Emergency Care Form**
• **Food**		Foods_____ Epinephrine ☐ Yes ☐ No If Yes, Date received _____
• **Food Intolerance**		Foods_____ Gastrointestinal/Digestive Distress ☐ Yes ☐ No Dietary Restriction/Preference ☐ Yes ☐ No
• **Bee Sting-** symptoms ***other*** than local redness/swelling		Epinephrine ☐ Yes ☐ No If Yes, Date received _____
• **Latex**		
Anxiety		Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Blood Disorder		
Cancer		Currently Immunocompromised ☐ Yes ☐ No
Dental/Oral Health Condition		
Depression		Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Diabetes		Method of Insulin Administration: ☐ Syringe ☐ Pen ☐ Pump
Eating Disorders		Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Heart		
Kidney/Urinary Tract Disorders		
Migraines		

(OVER)

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HEALTH INFORMATION

Complete this form annually to inform us about your student's health condition that affects his or her school day

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

Section C: Current Health Conditions Continued

Condition	Check if Yes	Comment
Muscle/Bone/Joint		
Respiratory • **Asthma**		**Triggers:** ☐ **Exercise** ☐ **Environmental** ☐ **Other** _____ **Number of Emergency Room (ER) Visits in the last calendar year:**
• **Cystic Fibrosis**		
• **Lung Disease (other than Asthma)**		**Type** _____ **Date of last episode** _____
Seizure/Neurological		
Skin Condition		☐ **Eczema** ☐ **Other** _____
Stomach/Bowels (IBS, Crohn's etc.)		
Other Health Concerns		
Vision Conditions:		☐ **Contacts/Glasses** ☐ **Non-correctable** ☐ **Other** _____
Hearing Conditions:		☐ **Hearing Aid(s)** ☐ **Other** _____

Section D. Health Procedures

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

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

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 Public Health Nurse. ☐ Yes ☐ No

_____ _____
Healthcare Provider Name Healthcare Provider Phone

_____ _____ _____
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 Conditions List (Medical Flag) ☐ 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 request 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 physician, 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 physician/provider to clarify information provided on the authorization 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. PHYSICIAN 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

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 ☐ From _____ To _____

If the student is taking more than one medication at school, list sequence in which medications are to be taken _____

_____ _____ _____ _____
Physician Name (Print or Type) Physician Signature Telephone or Fax Date

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

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate

☐ Parts I and II above are complete including signatures. (It is acceptable if all items in part II are written on the physician's stationery or a prescription pad.)
☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent.
(Within one week after expiration of the physician order or on the last day of school.)

_____ _____
Principal or 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 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 physician 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.

3. A physician 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. milligrams per tablet, milligrams per ml/cc) as applicable
   - 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 of medication order or effective dates
   - Physician's signature
   - Date

4. All prescription medications, including physician's prescription drug samples, **must** be in their original containers and labeled by a physician 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
   - Exact dosage to be taken in school (e.g. milligrams per tablet, milligrams per ml/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 the effective date on the physician order, or on the last day of school, the parent or guardian must personally collect 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. Parents 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/guardian must provide a supply of medication to FCPS and SACC for medication required to be administered during the school day and in SACC.

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INHALER AUTHORIZATION

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 permit the student identified below to use an inhaler in school as prescribed. 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 with the inhaler, provided FCPS, FCHD, and SACC personnel are following physician orders in part II.

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 all the required clearances have been personally reviewed by the principal or his or her designee. I give permission to contact the below named physician/provider to clarify information provided on the inhaler authorization form should the need arise.

_____ _____ _____
Parent or Guardian Signature | Daytime Telephone | Date

PART II PHYSICIAN TO COMPLETE INFORMATION SHOULD BE WRITTEN IN LAY LANGUAGE WITH NO ABBREVIATIONS

Diagnosis	List triggers
Medication	Dosage to be given at school or SACC
Symptoms or activity for which medication is ordered	Time(s) medication is given
Effective date ☐ Current School Year ☐ From _____ To _____	Time interval for repeating dosage

If the student is taking more than one medication at school, list the sequence in which medications are to be taken

Check the appropriate box:

I believe that this student has received adequate information on how and when to use an inhaler and that he or she can use it properly.

☐ The student is to carry an inhaler during school or SACC hours with the principal's knowledge. (An additional inhaler, to be used as backup, may be kept in the school health room or other approved school location.)

☐ The inhaler will be kept in the school health room or other approved location (specify) _____

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

_____ _____
Student Signature
(Required if student carries inhaler) | Date

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate:

☐ Parts I and II above are complete including signatures. (It is acceptable if all items in part II are written on the physician's stationery or a prescription pad.)

☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent.
(Within one week after expiration of the physician order 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 INFORMATION ABOUT INHALER PROCEDURES

1. Nonessential medication will not be permitted in school during school hours or during school-sponsored activities or SACC. Any medication taken in school or at SACC must have the parent or guardian-signed authorization and physician order if required by regulation.

2. The parent or guardian is responsible for obtaining the physician's statement in part II.

3. A physician 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 order
   - Duration of medication order and effective dates
   - Reason for medication or diagnosis
   - Name of medication
   - Exact dosage to be taken in school
   - Time to take medication and frequency or exact time interval dosage is to be administered
   - 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.)
   - Symptoms, other medications the student is taking
   - Statement that the student may self-administer
   - Physician's signature
   - Date

4. Physician samples must be appropriately labeled by the physician to include information requested in item 3 above.

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

6. Inhaler 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.

7. 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.

8. Within one week after expiration of the effective date on the physician order, or on the last day of school, the parent or guardian must personally collect 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.

9. 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.

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

EPINEPHRINE AUTHORIZATION

FAIRFAX COUNTY PUBLIC SCHOOLS

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 physician (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 physician's order (part II.) I am aware that the injection may be administered by a specifically trained nonhealth professional. I have read the procedures outlined on the back of this form and assume responsibility as required.

I understand that emergency medical services (EMS) will always be called when epinephrine is given, whether or not the student manifests any symptoms of anaphylaxis.

Student Name (Last, First, Middle)			
Date of Birth	School Name	School Year	Grade

No School Board employee, public health nurse, or clinic room 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 physician/provider to clarify information provided on the authorization should the need arise.

Parent or Guardian Signature _____ *Daytime Telephone* _____ *Date* _____

PART II PHYSICIAN TO COMPLETE

Emergency injections are usually administered in FCPS or SACC by nonhealth professionals. These persons are trained by the school public health nurse to administer the injection. For this reason, only premeasured doses of epinephrine may be given. It should be noted that these staff members are not trained observers. They cannot observe for the development of symptoms before administering the injection.

The following injection will be given immediately after report of exposure to _____
Indicate specific allergen(s) or unknown

Route of exposure: ☐ Ingestion ☐ Skin contact ☐ Inhalation ☐ Insect sting or bite

OR

The following symptoms

☐ Sudden difficulty breathing, wheezing
☐ Swelling of the throat, lips,tongue, tightness/change of voice, difficulty swallowing.
☐ Tingling sensation, itching, or metallic taste in mouth
☐ Feeling of apprehension, agitiation
☐ Vomiting PLUS one of the above symptom
☐ Other _____

Check the appropriate boxes:

☐ Give the premeasured dose of 0.3mg epinephrine 1:1000 aqueous solution (0.3cc) by autoinjection.
☐ Repeat dose in ☐ 5 minutes ☐ 10 minutes ☐ 15 minutes if EMS has not arrived. (Two premeasured doses will be needed in school.)

☐ Give the premeasured dose of 0.15mg epinephrine 1:2000 aqueous solution (0.3cc) by autoinjection.
☐ Repeat dose in ☐ 5 minutes ☐ 10 minutes ☐ 15 minutes if EMS has not arrived. (Two premeasured doses will be needed in school.)

Check the appropriate box:

I believe that this student has received adequate information on how and when to use epinephrine.

☐ The student is to carry an epinephrine autoinjector during school hours with the principal's knowledge. One additional dose, to be used as backup, should be kept in health room or other approved school location.
☐ The student can use the epinephrine autoinjector 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 autoinjector will be kept in the school health room.

Effective date: ☐ Current school year ☐ From _____ To _____

Physician Name (Print or Type) _____ *Physician Signature* _____ *Telephone or Fax* _____ *Date* _____

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

Student Signature _____ *Date* _____
(Required if student carries epinephrine)

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate:

☐ Parts I and II above are complete including signatures. (It is acceptable if all items in part II are written on the physician's stationery or a prescription pad.)

☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent.
(Within one week after expiration of the physician order 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.

SS/SE-64 11/15 Distribution: Original-School, Copy-Parent or Guardian

PARENT INFORMATION ABOUT EPINEPHRINE PROCEDURES

1. Epinephrine may be given in school, during school-sponsored activities, or at SACC only with both physician and parent or guardian-signed authorization.

2. This form must be on file in the health room or in an other approved location. The parent or guardian is responsible for obtaining the physician's statement in part II. For a student who attends SACC, a copy of the medication form must be on file with SACC.
3. A new form 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. A physician may use office stationery or a prescription pad in lieu of completing part II. Information necessary includes:

    - Name of student
    - Specific allergen(s) for which epinephrine is being prescribed
    - Route of exposure (e.g., ingestion, skin contact, inhalation, or insect sting or bite)
    - Brand name of medication
    - Amount of premeasured epinephrine
    - Time for repeated dose if deemed necessary
    - Duration of medication order and effective dates
    - Physician signature
    - Date

5. Only premeasured doses of epinephrine may be given by FCPS, FCHD, and SACC staff members.

6. Medication must be properly labeled by a pharmacist. If a physician's orders include a repeat of the epinephrine injection, then the parent or guardian must supply the school with two epinephrine autoinjectors. For a student who carries his or her own epinephrine autoinjector, the parent must supply the school with a back up that is stored in the health room or other approved location. Expiration date must be clearly indicated on the pharmacy label or autoinjector. The parent must provide a replacement epinephrine autoinjector when notified that the current autoinjector 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 collect any unused epinephrine within one week after the end of expiration of the order 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