Kannapolis City Schools Overnight Travel Medical Packet

January 2023

Kannapolis City Schools Overnight Fieldtrip
Procedure for Medicines

Dear Parent(s)/Guardian,

Please follow the guidelines below for your child if he/she needs medicine during the overnight field trip. Please note the KCS medication policy is the same on any field trip, including overnight, as it is during regular school hours. If you have any questions or concerns, please contact your School Nurse.

1. **Any medications that are currently kept in the School Nurse's office will be sent on the field trip to be given as ordered by the medical provider. No additional paperwork is needed.**

2. **If your child normally takes medicine outside the school hours and will need to take it while on the field trip, please follow the guidelines below:**

    - **Prescription or over-the-counter medicine to be given by school staff** must have medicine order completed and signed by a medical provider. Parent must sign medicine order allowing school staff to give medicine. Medicine must be sent in a pharmacy bottle with prescription label or in the original container with your child's name and least amount needed. Medicine and order must be given to the School Nurse to review before the field trip.

    - **Prescription medicine to be self-administered by the student** must have a medicine order completed and signed by a medical provider. Parent needs to sign medicine order allowing the student to self-medicate. Student will need to meet with the School Nurse to complete self-med contract before the field trip. Medicine must be sent in the original container with prescription label and least amount needed. Medicine order must be given to the School Nurse to review before the field trip.

    - **Over the counter medicines to be self-administered by the student** must have a note from parent attached to medicine allowing the student to self-medicate. Note must include medicine name, amount, time and parent signature. Medicine should be sent in its original container with student's name on it and least amount needed.

All medicine orders and/or medicines for the overnight field trip are due to the School Nurse to review by _____(date).

Thank you for helping to make this a fun and safe trip for your child. Please call if you have any questions.

_____ _____

School Nurse Phone Number

Student Overnight Travel

Student Insurance Waiver Form/Permission to Treat

Important: This notification MUST be signed and returned before your student can participate in this travel.

Student's Full Name:_____

Home Address:_____

Home Phone #:_____Parent/Guardian Cell #_____

Overnight Student Travel To:_____

STUDENT INSURANCE WAIVER

For overnight travel, student insurance must be taken unless this insurance waiver form is signed by the parent/guardian indicating adequate personal insurance. This waiver releases the Kannapolis City Board of Education and its employees from responsibility for any claim due to injuries received while participating in a school-sponsored overnight travel.

1. Pursuant to Board Policy 4220 and the current Student Accident Coverage Insurance I wish to proceed as follows: (Check One)
   a. I have adequate personal insurance and release the Kannapolis City Board of Education and its employees from any responsibility in this matter. My medical insurance information follows:

      Insurance Company_____ Policy #_____

      Co. Phone #_____ Name of Insured:_____

   b. My son/daughter is already enrolled in the current Student Accident Coverage Insurance program. I understand that I am responsible for payment of any charges not covered by this policy.
   c. _____I need to purchase the current Student Accident Coverage Insurance. I am enrolling my son/daughter online by going to https://www.kandkinsurance.com/sites/K12Voluntary/Pages/Home.aspx and following enrollment instructions.

2. There are limitations in the Student Accident Insurance coverage. The responsibility to pay for any necessary medical treatment not covered by the Student Accident Insurance coverage or personal insurance coverage belongs to the family.
3. Neither the Kannapolis City Board of Education nor any of its employees will assume responsibility for claims resulting from injury to your child while he or she is participating in this program.

PERMISSION TO TREAT

I give permission for my son/daughter, _____, to be treated in case of a medical emergency. I understand in the case of an emergency my child will be taken to the nearest medical treatment facility immediately and I will be contacted. In the case I am not able to be reached, I am providing the names of two emergency contacts.

1. Name:_____ Phone#_____

   Relationship:_____

2. Name:_____ Phone#_____

   Relationship:_____

Parent/Legal Guardian Signature:_____ **Date:**_____

Medication Authorization for Students

Student's Name:_____ **Date of Birth:**_____

School Year:_____ **Grade:**_____

In order to keep this student in optimum health and to help maintain maximum school performance and sustain attendance, it is necessary that medication be given during school hours.

Name of medication:_____

***Only one medication on each med auth form.**

Circle One: Tablet Capsule Liquid Inhaler Nebulizer* Patch Drops Injection* Rectal* Other:_____

*Please indicate physical condition for which specialized physical health care (nursing type) procedure is to be provided:

_____

Dosage (amount to be given)_____

Time/Frequency_____ **A.M.** _____**P.M. or As Needed Every**_____

Reason for Medication_____

Side Effects (expected or predicable)_____

Termination Date_____ (All medication orders expire at the end of the school year unless otherwise stated.)

Physician's Signature:_____ **Date:**_____

Physician's Name Printed:_____ **Telephone#**_____

Parent Authorization: Please sign the authorization that applies to your child below.

Parent permission for medication to be administered by the school nurse/staff:

- I hereby give my permission for my child (named above) to receive medication during school hours.
- This medication has been prescribed by a licensed physician.
- I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.
- This consent is good for the school year, unless revoked.
- I will furnish all medication for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

Parent/Guardian Signature: _____Phone: _____ Date: _____

OR

Parent Permission for medication to be SELF-ADMINISTERED by their child (K-5 consult with School Nurse):

- I agree to the Medication authorization as written by the above medical provider.
- I hereby request that my child be allowed to carry and self-administer the medication at school as prescribed by my child's licensed health care provider. I understand my child must carry this medication at all times in school or he/she will lose the right to carry it. I further understand that the school undertakes no responsibility for the administration of the medication. I hereby release the School Board, its agents and employees, from any and all liability that may result from my child taking this medication. My child is knowledgeable about this medication and how to self-administer it.
- I agree to ensure that the medication will have a pharmacy label with my child's name.

Parent/Guardian Signature: _____Phone: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Student's Name: _____ Grade: _____

Important Information about Medication Administration in Schools

- When possible, medications should be taken before or after school.
- Written parent/guardian consent and an order from a licensed healthcare provider are required for administering prescription and over-the-counter medications at school. Contact the school nurse for help if relocating to Cabarrus County. Some medications may not be suitable for a school setting. Contact the school nurse if you have questions.
- No medication will be given at school until this authorization has been reviewed and signed off by the School Nurse.
- Medications are given by a nurse or school staff trained by the School Nurse.
- Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.
- Medications kept in the school health office will be sent on school sponsored field trips.
- Medications stored in the school health office will not be available during non-school hours. It is the responsibility of the parents/guardians to assure that necessary emergency medications are available to students during non-school hours for before or after school clubs/programs.
- Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.
- The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication.
- New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.
- When a student self-administers an OTC medication without school staff support, the drug must be sent in the original container with only 1or 2 doses with a written authorization signed by the parent and attached to the container. The authorization must also include the date, time and amount of medication to be self-administered by the student.

Student Contract for Self-Administered Medication

Student Responsibilities:

- I plan to keep my inhaler, equipment, Epi-pen, or other medication with me at school rather than in the school nurse's office.
- I agree to use my inhaler, equipment, Epi-pen or other medication in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the school health office or main office if I am having more difficulty than usual with my health condition.
- I will not allow any other person to use my inhaler, equipment, Ep-pen or other medication.
- I will carry the lease amount of medication possible in its original container.

Student Signature_____ **Date**_____

School Nurses Responsibilities:

- Emergency Action Plan complete and on file at school
- Demonstrates correct use/administration
- Recognized proper and prescribed timing for medication
- Agrees to carry medication or keep in an established location
- Knows health condition well
- Keeps a second labeled container in the health room
- Will not share medication or equipment with others
- Comments

School Nurse Signature_____ **Date**_____

Policy for Over-the-Counter Medication Self-Administered by Students

When a student self-administers an OTC medication without school staff support, the drug must be sent in the original container with only 1 or 2 doses with a written authorization signed by the parent/guardian and attached to the container. The authorization must also include the date, time, and amount of medication to be self-administered by the student.