Form 2340 F2A
Effect. 12-12-94

# WARREN WOODS MIDDLE SCHOOL

## ***Parent Permission Form for Field Trip Participation***

Dear Parent or Legal Guardian:

Your son/daughter is eligible to participate in a school-sponsored activity requiring transportation to a location away from the school premises. This activity will take place under the guidance and supervision of employees from Warren Woods Public School District. A brief description of the activity follows:

| | | |
|---|---|---|
| 8th Grade Washington, DC Trip<br>**Activity Name** | Washington Committee<br>**Sponsor** | ★<br>**Student Name** |
| 5/18/23 - 5/22/23<br>**Dates to Students** | Motor Coach Bus<br>**Type of Transportation** | ★<br>**Street Address** |
| $867<br>**Cost to Student** | 8:00 PM on 5/18/23<br>**Planned Time of Departure** | ★<br>**City, Zip Code** |
| Gettysburg, PA, Washington, Virginia<br>**Locations of Activities** | 8:30 AM on 5/22/23<br>**Planned Return Time** | ★<br>**Parent/Guardian Name(s)** |
| | When Trip Returns to WWMS.<br>**Time Supervision Ends** | ★<br>**Telephone Number (Cell/Home)** |

If you would like your child to participate in this event, please complete, sign, and return the following statement of consent and release of liability. As parent or legal guardian, you remain fully responsible for the actions and conduct of your child.

STATEMENT OF CONSENT

I hereby consent to participation by my child, ★ in the event described above. I understand that this event will take place away from the school grounds and that my child will be under the supervision of the designated school employee on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

In consideration of my child being allowed to participate in this field trip, I agree to indemnify and hold harmless Warren Woods Public School District, any and all affiliated organizations, their employees, agents, and representatives, including volunteer and other drivers, from any and all claims, including negligence, arising from our relating to my child's participation in this field trip. This indemnification and hold harmless agreement does not apply to claims for intentional misconduct or gross negligence.

| ★ | ★ | ★ |
|---|---|---|
| Print Parent's Name | Parent's Signature | Date |

Please complete **FRONT** and **BACK** of this form and return it to
**Mrs. Everham's Mailbox in the Office - ASAP**

# STUDENT MEDICAL RELEASE FORM

School / Group Name: Warren Woods Middle School  Event Dates: 5/18/23-5/22/23

Student's Full Legal Name: ★

Home Address: ★

City: ★ State: ★ Zip: ★ Student's Date of Birth: ★ /  /

Home Phone ★ Work **(Mother)** ★ Work **(Father)** ★

Mother's Cell Phone ★ Father's Cell Phone ★ Other ★

**List the name and phone number of two parties who can be called if parents cannot be reached**

Emergency Contact ★ Phone ★

Emergency Contact ★ Phone ★

Doctor's Name ★ Phone ★

**Daily Medication:**
If your child will take ANY medications (*prescription and non-prescription*) during this school sponsored event, you will need a doctor's signature on the "***Medication/Parent Authorization Form***".

Prescription: ★

Non-Prescription: ★

**Please check any or all of the following medical conditions that apply to your child.**
(In addition to the **"MEDICATION / PARENT AUTHORIZATION FORM"**, your child will need a specific **"HEALTH PLAN"** form filled out and signed by the doctor for any of these serious medical conditions.)

★ ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Serious Allergy (bee stings, peanuts, etc.) ☐ Other _____

Other Medical Conditions: ★

This trip involves considerable walking. List any physical problems/concerns that the chaperone should be made aware:
★

**Insurance Information:** If the information is not known, write **N/A**. If you do not have insurance, write **NONE**

Company Name: ★ Phone ★ Student Blood Type ★

Policy Number: ★ Name of Policy Holder: ★

- In the event of a medical emergency, I authorize the chaperones to make the necessary decisions for the safety of my child's health.
- I also understand that the behavior of my child on this trip will not bring discredit to the school or other people in the group.
- All Warren Woods Middle School rules are in effect for this school sponsored trip.

★ Parent/Guardian's Signature  ★ Date  ★ Parent/Guardian's Printed Name

# Washington DC Eligibility Requirement Contract

Your child has the opportunity to attend an educational and exciting field trip to Washington DC. Because appropriate behavior is essential on all field trips, students must meet the following criteria in order to be eligible.

- If a student receives 2 or more "Ds" or 1 or more "Fs" on an 8th grade report card he/she will be placed on academic probation. This means he/she is still eligible to go on the trip and payments can still be made. If the student does not improve these grades by the middle of 3rd quarter he/she will be ineligible for the trip.
    - This does not apply to students who are showing their best effort and receiving low grades.
- If a student receives 2 or more "Ds" or 1 or more "Fs" in citizenship on an 8th grade report card he/she will be placed on behavior probation. If the student does not improve these marks by the middle of 3rd quarter he/she will be ineligible for the trip.
- If a student receives 3 or more office referrals, or 4 or more caution cards, he/she will be ineligible for the trip.
- If a student has been suspended for any reason, at any time during 8th grade, he/she will be ineligible for the trip.
- Any unpaid fees to the school will need to be taken care of before the trip or he/she will be unable to attend.
- If a student has excessive unexcused absences and/or tardies in 8th grade he/she will be placed on probation. If there is no improvement by the middle of the 3rd quarter he/she will be ineligible.
- **Teachers and administrators reserve the right to determine a student's final eligibility for trip participation.**

> ✳ ***Any student who falls under the criteria above has the right to an appeal.***

These criteria have been developed to ensure that our students uphold the high expectations for behavior that Warren Woods Middle School expects from students. Please sign and date below, and return this entire form to Mrs. Everham. There are extra copies of these criteria on the WWMS website and the cart outside of room 309.

**I have read and understand the above criteria, and have discussed these with my child. I understand that if my child does not meet these criteria, he/she is ineligible for the 8th grade Washington DC trip.**

★_____ ★_____ ★_____

***Print PARENT/GUARDIAN'S Name*** ***PARENT/GUARDIAN'S Signature*** ***Date***

**I have read and understand the above criteria, and have discussed these with my parent/guardian. I understand that if I do not meet these criteria, I am ineligible for the 8th grade Washington DC trip.**

★_____ ★_____ ★_____

***Print STUDENT'S Name*** ***STUDENT'S Signature*** ***Date***

**WARREN WOODS PUBLIC SCHOOLS**
**MEDICATION / PARENT AUTHORIZATION FORM**

Student Name ★_____ School: Warren Woods Middle School

Birth Date: ★____/____/____ Grade: 8 School Year: 2022-2023

## ★ TO BE COMPLETED AND SIGNED BY PHYSICIAN / LICENSED PRESCRIBER ★

| | MEDICATION #1 | MEDICATION #1 | MEDICATION #1 | MEDICATION #1 |
|---|---|---|---|---|
| **MEDICATION NAME** | | | | |
| **START DATE? STOP DATE?** | | | | |
| **DOSAGE** | | | | |
| **TIME(S) GIVEN** | | | | |
| **FORM/ROUTE (Circle One)** (see note below chart) | ORAL<br>INHALED<br>TOPICAL APPLICATION<br>INJECTION | ORAL<br>INHALED<br>TOPICAL APPLICATION<br>INJECTION | ORAL<br>INHALED<br>TOPICAL APPLICATION<br>INJECTION | ORAL<br>INHALED<br>TOPICAL APPLICATION<br>INJECTION |
| **SIDE EFFECTS** | | | | |
| **ADVERSE REACTIONS** | | | | |
| **REASON(S) FOR MEDICATION** | | | | |
| **SPECIAL INSTRUCTIONS** (List minimal frequency between doses) | | | | |
| **ROUTES:** *__ORAL__ (pill/capsule/chewable, liquid) ***TOPICAL APPLICATION** (eye drop, ointment, ear drop) *__INHALED__ (inhaler, nebulizer) ***INJECTION** | | | | |

★ □ I request that my child be assisted by authorized school personnel in taking the described medication at school according to Board of Education Policy #5330.

□ I request that my child be allowed to self-administer the above medication at school according to school policy.

□ I authorize school personnel to administer: ☐ Glucagon ☐ Epinephrine ☐ Other _____
If based on their observation, they believe a life-threatening condition exists. I hereby release Warren Woods and its personnel from any and all liability that may result from their determination that a life threatening condition exists.

□ This student is capable and responsible for carrying and self administering ☐ Epi-Pen ☐ Inhaler

★ These are the ONLY two medications that a student may carry. All other medications must be stored in the counseling office or carried by a chaperone during a school trip. A second Epi-Pen or Inhaler must be stored in the school office. ★

★_____ Physician's Signature ★_____ Date ★_____ Physician's Printed Name

★(____)_____ Physician's Phone Number ★(____)_____ Physician's Fax Number ★_____ Physician's Address

I request and give permission for (name of child) ★_____ to receive the above medication(s)/treatment at school (or during school related events) according to standard school district policy, and for the physician('s) staff and school district to share information needed to assist my child with medication needs.
(School requires parent/guardian to bring medication in its original container.)

- I will assume responsibility for safe delivery of the medication to school, by either me or my child.
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

★_____ Parent/Guardian's Signature ★_____ Date ★_____ Parent/Guardian's Printed Name

# *This page to be completed by Parent/Guardian*

**Student Name _____ School Year_____**

Child's Picture

**Warren Woods Public Schools**

**Asthma School Health Plan**

**Student Name_____**

**Date of Birth _____ Age_____ Grade ___ School_____**

***Note: This school health plan must be signed by parent and physician/licensed prescriber. Without signatures this plan is not valid.***

CONTACT INFORMATION

| | **Call First** | **Try Second** |
|---|---|---|
| Parent/ Guardian: | Name:_____ | Name:_____ |
| | Relationship: _____ | Relationship: _____ |
| Phone: | Home: _____ | Home: _____ |
| | Cell: _____ | Cell: _____ |
| | Work: _____ | Work: _____ |

**Call Third (If Parent/guardian cannot be reached)**

Name: _____ Relationship: _____

Address: _____ Phone: _____

Asthma History

Asthma Triggers (exercise, cold, foods, etc.) _____

Equipment (check all that apply): Medication __ Inhaler __
Spacer __ Nebulizer __ Peak Flow Meter__

If my child is to carry an inhaler, I will also supply the school office with a back up inhaler
___Yes ___ No

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having asthma to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) **I give permission for trained staff to help administer medication ordered for asthma and to contact the physician/licensed prescriber for clarification of orders & medical information if needed.**

Date: _____ Parent/Guardian Signature: _____

Sources: Michigan State Board of Education Policy on the Management of Asthma in Schools, Thomas F. Plaut, M.D. Asthma Emergency Guide, School Guidelines for the Nurse in the School Setting-Illinois Emergency Medical Services for Children

# *This page to be reviewed & signed by Physician/Prescriber*

**Student Name _____ School Year_____**

**Signs of Asthma Attack**

- Wheezing
- Shortness of breath
- Difficulty breathing
- Prolonged coughing
- Complains of chest tightness or pressure
- Anxious appearance
- Inability to speak in a full sentence without taking a breath, or only able to whisper
- Need to stand or lean over at waist
- Peak Flow reading below 80% of personal best

**Action**

- Allow student to use his/her medication as ordered below
- Use a spacer if provided for a metered dose inhaler
- Be sure to wait 1-2 minutes before a second puff of the inhaler
- Remain calm
- Encourage slow, deep breathing: in through the nose & out through puckered lips
- Have student sits upright
- Stay with the student until breathing normally
- Contact parent

If no medication is available:

- Continuously observe student
- Notify parent to provide medical care
- Call 911 as indicated below

**Signs of Asthma EMERGENCY**

- No improvement 10-15 minutes after medication is given
- Breathing difficulty gets worse
- Skin pulls in around collarbone or ribs with each breath(shoulders may rise)
- Looks anxious, frightened, or restless
- Stops playing and cannot start activity again
- Trouble walking or talking
- Hunched over
- Lips or tips of fingers (nail beds) are blue or gray
- Peak flow reading less that 50% of personal best

**Action**

- CALL 911 and Parent/Guardian
- Repeat medication while waiting for emergency help to arrive
- Start CPR if breathing stops

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Medication: _____ Route __ MDI (Metered Dose Inhaler) Dose: _____
__ Nebulizer (Breathing Machine) Dose: _____

MDI Treatment may be repeated in 5 to 10 minutes if no help or symptoms worse __Yes _ No

Nebulizer instructions_____

Medication is needed 20 minutes before PE/recess/strenuous exercise __ Yes __No

Student can use inhaler correctly, knows when to get adult help, not to share, and how to properly maintain the device. Therefore in my professional opinion, this student should be allowed to self carry their inhaler. __ Yes __ No

Peak Flow Readings are to be done at school __ Yes __ No Give Medication for a PF Reading below _____
Personal Best Peak Flow_____
Other instructions/orders _____

Physician/Licensed Prescriber Name _____

Phone Number _____ Fax Number _____

Signature _____ Date _____

# Warren Woods Middle - 8th Grade

## Gettysburg & Washington DC, May 18th to May 22nd, 2023

Student Adventures
On the Road to Discovery

### Friday May 19th, 2023

| | |
|---|---|
| | Trip Check-in Thu May 18th 8:30 PM<br>Trip Departs 9:00 PM |
| 7:00 AM | Breakfast at Dobbin House<br>(Included) |
| 8:00 AM | 2 Hour Gettysburg Battlefield Tour<br>Licensed Guide-for each bus |
| 10:00 AM | Gettysburg National Military Park<br>Visitors Center |
| 11:00 AM | Lunch-Outlet Shoppes @Gettysburg<br>(Meal Voucher) |
| 2:00 PM | Group Photo on Capitol Steps<br>(Pre-order upon trip sign up) |
| 2:00 PM | Group Photo on Capitol Steps<br>(Pre-order upon trip sign up) - Optional |
| 3:20 PM | U.S. Capitol Tour - pending<br>Lib of Cong & Sup Court Stops After |
| 5:30 PM | Dinner at Pentagon City Mall<br>($15 Cash Allowance) |
| 6:30 PM | Illuminated Memorial Tour<br>Certified DC Guide-for each bus |
| 7:00 PM | WWII/Vietnam/Lincoln/Korean<br>Einstein Statue Photo |
| 10:00 PM | All Students in Rooms<br>Nighttime Security 10pm-5am |

### Saturday May 20th, 2023

| | |
|---|---|
| 6:00 AM | Wake-Up Calls |
| 6:30 AM | Breakfast at Hotel<br>(Included) |
| 7:30 AM | Depart Hotel |
| 9:00 AM | Visit National Zoo |
| 10:15 AM | Depart Zoo for Ford's |
| 11:00 AM | Ford's Theatre<br>Museum w/ One Destiny Performance |
| 12:30 PM | Lunch at Ronald Reagan<br>(Food Voucher) |
| 2:00 PM | Full Day Guided Tour<br>Certified DC Guide-for each bus |
| 2:30 PM | Visit Arlington Cemetery<br>Marine Corps Memorial After |
| 3:15 PM | Tomb of the Unknown Soldier<br>Wreath Laying Ceremony |
| 5:00 PM | Dinner at Pentagon City Mall<br>($15 Cash Allowance) |
| 6:00 PM | Pentagon 9/11 Memorial<br>Jefferson/FDR/MLK Jr. Memorials |
| 9:30 PM | Depart for Hotel |
| 10:30 PM | All Students in Rooms<br>Nighttime Security 10:30pm-5:30am |

### Sunday May 21st, 2023

| | |
|---|---|
| 6:00 AM | Wake-Up Calls |
| 6:30 AM | Breakfast at Hotel<br>(Included) |
| 7:30 AM | Depart Hotel |
| 8:00 AM | George Washington's Mount Vernon<br>Self Guided Visit |
| 10:30 AM | Depart Mt. Vernon<br>Meet Outside of Gift Shop |
| 11:30 AM | Lunch-Food Trucks or L'Enfant<br>Plaza ($15 Cash Allowance Provided) |
| 1:00 PM | U.S. Holocaust Memorial Museum<br>(pending availability) |
| 3:00 PM | Explore Smithsonian Institutions |
| 5:45 PM | White House Photo Stop |
| 6:30 PM | Spirit Cruise Boarding<br>(Included) |
| 7:00 PM | Dinner-Spirit Cruise<br>DJ Dance |
| 10:15 PM | Depart for Home |
| | Trip Returns Mon May 22nd 8:30 AM |

SCAN ME



Your Tour Consultant is David Johns CALL: 8109532052 EMAIL: info@studentadventures.org

# *This page to be completed by Parent/Guardian*

**Student Name _____ School Year_____**

Child's Picture

**Warren Woods Public Schools**

**Diabetes School Health Plan**

**Student Name_____**

**Date of Birth _____ Age_____ Grade ___ School_____**

***Note: This school health plan must be signed by parent and physician/licensed prescriber. Without signatures this plan is not valid.***

CONTACT INFORMATION

| | | **Call First** | **Try Second** |
|---|---|---|---|
| Parent/ Guardian: | Name: | _____ | _____ |
| | Relationship: | _____ | _____ |
| Phone: | Home: | _____ | _____ |
| | Cell: | _____ | _____ |
| | Work: | _____ | _____ |

**Call Third (If Parent/guardian cannot be reached)**

Name: _____ Relationship: _____

Address: _____ Phone: _____

## Diabetes Management

Age when diabetes diagnosed _____ Type 1 ____ Type 2 ___

Can student perform own blood glucose testing Yes ___ No ___
Please monitor/assist Yes ___ No ___
Location of supplies Office ___ Backpack ___

Blood Glucose Testing

- Daily before lunch
- As needed for symptoms of hypo/hyperglycemia/illness
- Other (please indicate) _____

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having diabetes to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) **I give permission for trained staff to help administer medication ordered for diabetes and to contact the physician/licensed prescriber for clarification of orders & medical information if needed.**

Date: _____ Parent/Guardian Signature: _____

Sources: Guidelines for the Nurse in the School Setting-Illinois Emergency Medical Services for Children, Helping the Student with Diabetes Succeed – CDC, H.A.N.D. S. – National Association of School Nurses, Michigan State Board of Education Approved Model Policy on the Management of Diabetes in the School Setting

# *This page to be reviewed & signed by Physician/Prescriber*

**SIGNS OF HYPOGLYCEMIA OF LOW BLOOD SUGAR**

- Hunger
- Dizziness
- Shakiness
- Sweating
- Lack of concentration
- Poor coordination
- Personality or behavior change
- Anxiety
- Crying
- Weakness
- Paleness
- Confusion
- Irritable

**Common Causes (Symptoms may be sudden)**

- Too much insulin
- Missed or delayed food
- Too much or too intensive exercise
- Unscheduled exercise

**ACTION**

- Check Blood Glucose
- If students has an insulin pump: check site, check tubing for disconnection, pump will alarm with malfunction
- Blood Glucose less than 65or 65-80 with symptoms
- Provide15 grams of carbohydrate (4oz of juice OR 3-4 glucose tablets)
- Wait 15 Minutes
- Recheck blood glucose
- Repeat treatment if blood glucose is less than 65
- If greater than 1 hour before a snack or meal, give a snack of carbohydrate and protein

**SIGNS OF EMERGENCY**

- Loss of consciousness
- Seizure
- Inability to swallow

**ACTION**

- Call 911
- Initiate Code Blue – Response Team
- DO NOT give anything by mouth
- Administer Glucagon as prescribed
- Position on side, if possible
- Stay with student
- Contact parents
- Monitor until EMS arrives
- Document on Incident/Accident report include time & dosage

## Hyperglycemia (High Blood Sugar)

**SIGNS OF HYPERGLYCEMIA- HIGH BLOOD SUGAR**

Increased hunger/thirst
Frequent urination
Fatigue/sleepiness
Blurred vision
Stomach pains
Lack of concentration

**Common Causes (happens slowly, hours to days)**

Too little insulin
Too much food
Decreased activity
Illness/infection or stress
Insulin pump malfunction

**ACTION**

Check Blood Glucose
If student has an insulin pump: check site, check tubing for disconnection, pump will alarm with malfunction
Check Urine Ketones if BS>300 or symptoms of severe hyperglycemia

- Negative or trace ketones
  - Give extra water or sugar free drinks
  - Allow use of bathroom as needed
  - Inform parents of frequent high readings
- Small Ketones
  - Give at least 8 oz. water every hour
  - Recheck ketones at next urination
  - Child cannot exercise if ketones present
  - Call parent
- Moderate to Large Ketones
  - Call parent
  - Encourage water until parent is contacted
  - If parent can not be reached notify physician
  - Child cannot exercise if ketones present

**SIGNS OF EMERGENCY**

- Nausea/vomiting
- Moderate to large ketones
- Sweet, fruity breath
- Labored breathing
- Confused
- Unconscious

**ACTION**

- Call 911 if student is unresponsive
- Call 911 if student has labored breathing
- Call 911 if student has abdominal pain, nausea/vomiting AND unable to reach parent/guardian

**Authorized Physician Order/Licensed Prescriber & Agreement with Protocol in this 2 page plan**

**Insulin** _____ Carb Ratio_____ Correction Factor _____ Target BS _____
Continuous Glocuse Monitor (CGM) **___ Yes ___ No**
Changes in insulin calculation to be determined by parent/guardian **___ Yes ___ No**
**Glucagon ___ Yes ___ No** (please circle correct dose) **Dose** 1 mg (entire vial) or **Dose** ½ mg (half of vial)
**Give as an injection (mix first) into leg muscle for severe hypoglycemia with unconsciousness, seizures, or inability to swallow.**
**Other instructions/orders**_____
**Physician/Licensed Prescriber** _____ **Phone** _____ **Fax** _____
**Signature** _____ **Date** _____

# Warren Woods MS - 8th Grade
# Gettysburg & Washington DC Trip
# 5/18/2023 - 5/22/2023

Student Adventures
On the Road to Discovery

### Trip Inclusions:

- 2 Hour Gettysburg Battlefield Tour
- Explore Smithsonian Institutions
- Ford's Theatre
- Full Day Guided Tour
- George Washington's Mount Vernon
- Gettysburg National Military Park
- Group Photo on Capitol Steps
- Illuminated Memorial Tour
- Pentagon 9/11 Memorial
- Spirit Cruise Boarding
- Tomb of the Unknown Soldier
- U.S. Capitol Tour - pending
- U.S. Holocaust Memorial Museum
- Visit Arlington Cemetery
- Visit National Zoo
- White House Photo Stop
- WWII/Vietnam/Lincoln/Korean

SCAN ME

**Trip Sponsor:** Amber Everham
**Email:** aeverham@mywwps.org

**Departing School May 18th, 2023 09:00 PM**

**Returning to School May 22nd, 2023 08:30 AM**

### Traveling By:

- 56 Passenger Motorcoaches from National Trails

### Accommodations:

- 2 Nights at Courtyard Marriott - Springfield, VA
- Quad Occupancy for Students (2 students per bed, 2 beds per room)
- Double Occupancy for Adults (1 Adult per bed, 2 beds per room)
- Nighttime security guards each night

### Meals Provided:

- 3 Breakfasts
- 3 Lunches
- 3 Dinners

Tour activities are subject to change based on availability or vendor restrictions. If this occurs, Student Adventures will arrange similar activities.

**Please note:** There is limited space on the trip. Seats are filled on a first come, first serve basis. Your seat will not be secured until you make your deposit payment.

**The deadline for registration is: Oct 7th, 2022**

### Registration Process:

- Visit www.studentadventures.org or download the Student Adventures TripApp
- Click the LOGIN button
- Sign up for EasyTrack
- Create your Account or login to an existing account
- If creating your account, you will receive an email to continue your registration
- Online Registration ID: **WW2255**
- Follow the online instructions and make a deposit payment to complete your registration
- Student Adventures cannot register participants over the phone

## Cost of your Trip:

- **$886.00 Student** (Quad Rm) + $105.00 CSP*

### Payment Schedule:

| Date Due | Amount |
|---|---|
| Upon Registration | $199.00 |
| Fri Nov 18th, 2022 | $199.00 |
| Fri Dec 16th, 2022 | $199.00 |
| Fri Jan 20th, 2023 | $199.00 |
| Fri Mar 17th, 2023 | $Balance |

### Please Note:

- * Cancellation Super Protector (CSP) is required for this trip. Full details available on our website: www.studentadventures.org or call 877-873-7550.
- Trip Cost Increases may be possible if fuel charges or price increases are assesed by our vendors.
- $35 Late fee if balance is not paid in full by final payment due date.
- View all additional charges online under Terms and Conditions.

# *This page to be completed by Parent/Guardian*

**Student Name _____ School Year_____**

Child's Picture

**Warren Woods Public Schools**

**Seizure School Health Plan**

**Student Name_____**

**Date of Birth _____ Age_____ Grade ___ School_____**

***Note: This school health plan must be signed by parent and physician/licensed prescriber. Without signatures this plan is not valid.***

**CONTACT INFORMATION**

| | **Call First** | **Try Second** |
|---|---|---|
| Parent/ Guardian: | Name:_____ | Name:_____ |
| | Relationship: _____ | Relationship: _____ |
| Phone: | Home: _____ | Home: _____ |
| | Cell: _____ | Cell: _____ |
| | Work: _____ | Work: _____ |

**Call Third (If Parent/guardian cannot be reached)**

Name: _____ Relationship: _____

Address: _____ Phone: _____

**SEIZURE HISTORY**

**Seizure Type**
**Description of seizure** _____

**How long does a typical seizure last** _____ **How often do seizures occur** _____

**Date of last seizure** _____

**Warning signs (aura) or triggers if any, please explain** _____

**Age when seizures were diagnosed** _____ **Date of last exam for this condition** _____

**Past history of surgery for seizures ___ Yes ___ No**

**Current Seizure Medications** _____

**Notify parent immediately for all seizure activity? ___ Yes ___ No**

**Other instructions** _____
**Any special considerations or safety precautions:**

---

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having seizures to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) **I give permission for trained staff to help administer medication ordered for seizure activity and to contact the physician/licensed prescriber for clarification of orders & medical information if needed.**

Date: _____ Parent/Guardian Signature: _____

***Revised 6/12***

# *This page to be completed by Physician/Licensed Prescriber*

**Student Name _____ School Year_____**

**Action if student has a seizure:**

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully awake
- Record seizure in a log

**If tonic clonic (grand mal) seizure:**

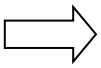
- Keep airway open/watch breathing
- Protect head
- Turn child on side, if able to safely
- Follow medical orders (last box below)

## After Seizure:

- Permit student to rest
- Continue to document the episode
- Monitor for confusion or lack of consciousness
- Monitor breathing
- Do not give student anything to eat or drink until fully conscious and aware of surroundings

## General Signs of a Seizure EMERGENCY

- Convulsion (tonic-clonic/grand mal) or per 911 instructions below in Order
- Student has repeated seizures without regaining consciousness
- Student is injured, has diabetes, or is pregnant
- Student has breathing difficulties, or normal breathing does not resume
- Student has a seizure in water
- Parents request an emergency evaluation



**ACTION: CALL 911**

- ✓ **Stay with the student until help arrives**
- ✓ **Call parent/guardian**
- ✓ **CPR if needed**

**Physician/Licensed Prescriber Order & Agreement with Protocol (as outlined in this 2 page plan)**

**___ Administer Diastat rectal gel for seizure lasting longer than _____ minutes. Dose _____**
**Other instructions for Diastat _____**

**___ No Diastat ordered**

**Does student have a Vagal Nerve Stimulator ___ Yes ___ No (If YES, special instructions:**

---

**Call 911 if: (please check and complete all that apply)**

- ⌗ **Seizure does not stop by itself within _____ minutes**
- ⌗ **Anytime Diastat is given**
- ⌗ **Only if a seizure does not stop within _____ minutes after giving Diastat**
- ⌗ **Other directions or medications:**

_____
_____

**Physician/Licensed Prescriber's Name _____**

**Phone Number _____ Fax Number _____**

**Signature _____ Date_____**

# *This page to be completed by Parent/Guardian*

**Student Name _____ School Year_____**

Child's Picture

**Warren Woods Public Schools**

**Severe Allergy School Health Plan**

**Student Name_____**

**Date of Birth _____ Age_____ Grade ___ School_____**

***Note: This school health plan must be signed by parent and physician/licensed prescriber. Without signatures this plan is not valid.***

## CONTACT INFORMATION

| | **Call First** | **Try Second** |
|---|---|---|
| Parent/ Guardian: | Name:_____ | Name:_____ |
| | Relationship: _____ | Relationship: _____ |
| Phone: | Home: _____ | Home: _____ |
| | Cell: _____ | Cell: _____ |
| | Work: _____ | Work: _____ |

**Call Third (If Parent/guardian cannot be reached)**
Name: _____ Relationship: _____
Address: _____ Phone: _____

## ALLERGIC HISTORY

**Has your child ever been given an epinephrine shot for an allergic reaction? ___ Yes ___No**

**Does your child have Asthma?** (If yes, at a higher risk for severe allergic reaction) **___ Yes ___ No**

**Note: if you child needs medication at school for asthma, please complete a separate ASTHMA Medical Action Plan**

**List all Allergic FOOD**
If nuts, please specify by circling one or both: Peanut Tree Nut

---

**Can student determine their own food choices at school? ___Yes ___ No**

**List of Different SEVERE ALLERGIES** (such as, Insect Sting or Latex)

---

If my child is to self-carry epinephrine, I will still supply the school office with a back up auto-injector. ___ Yes ___ No

## Note: Meals from home provide the safest food option at school.

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having severe allergies to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) **I give permission for trained staff to help administer medication ordered on page 2 of this severe allergy health care plan for allergic reactions and to contact the physician/licensed prescriber for clarification of orders & medical information if needed.**

Date: _____ Parent/Guardian Signature: _____

Source: School Based Allergy Management Plan pg 2 adopted from Food Allergy Network

# *This page to be completed by Physician/Licensed Provider*

**Student Name _____ School Year_____**

**Mild Symptoms (local reaction)**

**Mild Skin Reactions** - Hives/Swelling only in the area of allergen contact

- ✓ **Students with Adrenalin (Epi-Pen) or history of Anaphylaxis must go home with parental supervision for the remainder of the school day**

SYMPTOMS CAN BECOME MOVE SERIOUS VERY QUICKLY OR OVER THE NEXT SEVERAL HOURS

**Emergency Treatment**

**If student has mild symptoms or ingestion is suspected:**

- Remove object-casing reaction, as soon as any of the above reactions are noted.
- Rinse area with large amounts of water and escort student to front office if condition permits
- Contact school administrator
- Note time _____ (am/pm) and stay with student
- **Watch closely for any serious symptoms**
- Give antihistamine if ordered by doctor
- Call Parent or Emergency Contact (current Emergency Contact information is available from the school office)
- Stay with student until Parent or Emergency Medical services arrives
- If symptoms progress give Epinephrine (see serious symptoms below)

**DO NOT HESITATE TO CALL 9-1-1 OR TO GIVE EMERGENCY MEDICATIONS**

**SERIOUS SYMPTOMS (Systematic Reaction)**

- Throat – itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- Lung – shortness of breath, repetitive coughing or wheezing
- Heart – "passing out", blueness, pale, faint, weak pulse, dizzy, confused
- Mouth – itching & swelling of the lips, tongue, or mouth
- Skin – hives, itching rash, and/or swelling about the face or extremities
- Gut – nausea, abdominal cramps, vomiting and/or diarrhea

Or **combination** of symptoms from different body areas:
Skin: Hives, itchy rashes, swelling (e.g. eyes, lips)
Gut: Vomiting, crampy pain

**Emergency Treatment**

**IF STUDENT HAS ANY SERIOUS SYMPTOMS:**

- Note time _____ am/pm and stay with student
- Give _____ as ordered by doctor
- **ADMINISTER EPI PEN** injection, if ordered
  Follow direction on injection device as trained
  Note time given: _____ am/pm
- **Call 9-1-1**
- Dispose of used Epi-pen in safe, needle proof container and give to Emergency responders
- Give copy of "Emergency Action Plan" to emergency responders
- Call Parent or Emergency Contacts (current emergency contact information is available from the school office)

**Monitoring**
**Stay with student; call 911 and parent/guardian.** Tell rescue squad epinephrine was given. Note time epinephrine was given. For severe reaction, consider keeping student lying on back with legs raised. Keep head to the side if vomiting. Treat student even if parents cannot be reached.

**Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan**

**Epinephrine dose ___.15 mg (junior) ___ .3 mg (adult)** Auto injector brand name if known_____
**Two doses are to be made available at school ___ Yes ___ No**
**If yes, second dose may be given 5 minutes or more after the first if symptoms persist or recur.**

**It is my professional opinion that student should self-carry epinephrine ___Yes ___No**

**NOTE: If a student is to self-carry their epinephrine, help may still be needed to give the medication**.

**Antihistamine name**_____ **Dosage** (please do not give a range) _____

**Other instructions or orders** _____

**Physician/licensed prescriber name** _____

**Phone number** _____ **Fax number** _____

**Signature** _____ **Date** _____