A.P. 6153 – STUDENT TRIPS
Attachment 3 - Permission Slip

BOARD OF EDUCATION OF PRINCE GEORGE'S COUNTY

School:		**Date:**	

Dear Parent(s)/Guardian(s):

This is to inform you that the _____ is planning a field trip
(class, group, organization)

to _____ on _____
(destination) *(date)*

The sponsoring teacher for this trip is _____

The purpose of this trip is to _____

Students intending to participate in said field trip are expected to assemble at the school on the date of the trip at _____
(time)
Depending on the departure and/or return time, you may be responsible for transporting your child to and/or from school.

Transportation to and from the field trip destination will be provided by _____
(public school bus or authorized commercial carrier)

The cost to each participating student is $ _____ A deposit in the amount of $ _____ is due on or before _____
(date)

and the remaining balance of $ _____ is due on or before _____
(balance) *(date)*

Kindly make payments to the order of _____ which is handling all of the
(Name of authorized travel agency)

arrangements for this trip.

*In the event of cancellation, the Board of Education of Prince George's County shall assume no responsibility or liability for the failure of any travel agency or other source having assumed the responsibility of making travel arrangements, failing to issue refunds, in whole or in part, to the students originally anticipated to participate in the student trip. *You should also be advised that this payment may be non-refundable if your son/daughter cancels the trip participation and no substitute student can be found to take and pay for said trip in his/her place.*

Furthermore, please be informed that it is the policy of the Board of Education of Prince George's County that no student be denied the opportunity to participate in a Field Trip for reasons on inability to pay. Accordingly, if you are desirous of having your son/daughter participate in said Field Trip but are unable to pay therefore, please call me at your earliest opportunity.

**This field trip will be funded in part by Board of Education school budget funds.*

Sincerely,	Supplemental Information:

A.P. 6153 – STUDENT TRIPS
Attachment 3 - Permission Slip (CONT'D)

RETURN THIS COMPLETED FORM TO YOUR CHILD'S SCHOOL

School:			**Date:**	

I/We hereby give permission for our son/daughter _____ (*student's name*) to participate in the

field trip to _____ (*destination*) on _____ (*date*) for _____ (*class, group, organization*)

being sponsored by _____ (sponsoring teacher)

I/We hereby certify that the information to which this permission slip has been attached has been read by me/us.

Parent's Signature		**Date**
Enclosed: $		

Emergency Medical Treatment Authorization

Parents or Guardians (Please print):		
1.	Phone (w):	Phone (c):
2.	Phone (w):	Phone (c):
Emergency Contact: ***(if parents can't be reached)***		
1.	Phone (w):	Phone (c):

Student Health Information

1. Does your child currently have a Prescriber's Medication Order Form on file to receive authorized medication at school? Yes ☐ No ☐

A Prescriber's Medication Order Form ***and*** *medication(s) for all prescription and/or non-prescription medications (not administered at school) to the nurse properly labeled at least* ***30 days prior*** *to field trips to ensure adequate time for packing of medications as well as to train staff on mediation administration and documentation.*

2. Does your child have any medical conditions or disabilities? Yes ☐ No ☐
   If yes, please explain: _____
3. Does the above restrict any activities? If, yes, please explain below: Yes ☐ No ☐
4. Is your child covered by hospitalization and/or accident insurance? Yes ☐ No ☐

Name of Insurance Carrier: _____

Family Physician (Name and Phone): _____

Dentist (Name and Phone): _____

NOTE: In a serious emergency, your son/daughter may have to be taken to the nearest hospital emergency room. Should such action be necessary, you will be notified as soon as possible and will be responsible for any charges incurred. The school has no funds to meet the bills resulting from care, which is sought outside the school setting. It is important that you understand that your signature on this card does not give the hospital permission to treat your son/daughter.

Parent/Guardian			**Date:**	

Office of School Health
Parent Fact Sheet for Medication at School (PMOF)

Please note: Medications will be administered at school ONLY when it is ABSOLUTELY necessary. If it has been deemed necessary for medications to be administered at school, the following guidelines MUST be followed:

A. No medication will be administered to your child **without** a completed Prescriber's Medication Order Form (PMOF) and properly labeled medication container.

B. When medication is brought or sent to school please do the following:
   1. Notify the school staff prior to the medication being brought or sent to the school;

   2. A completed PMOF to accompany the prescription or non-prescription medication(s) which is completed with the prescriber's signature, address, phone number and current date. A new medication form MUST be submitted:

      - At the beginning of each school year (dated no more than 90 days prior to the next school year);
      - When there is a change in dosage, time, or frequency of the medication is to be given or specialized services;
      - Non-prescription medication (over-the-counter) must come to school in the original non-opened container

   3. Prescription medication will not be accepted by the school system unless the label matches the order and contains the following:
      - The pharmacy name, address, and phone number
      - Prescription number
      - Date prescription was filled
      - Name of student
      - Name of medication
      - Directions for administration
      - Quantity provided
      - Any special instructions (often a colored sticker)
      - Name of physician
      - Number of refills
      - Expiration dates (except for prescriptions filled in federal facilities)

C. **Parents MUST give the first dose** of any non-emergency NEW prescription or over-the-counter (OTC) drug;

D. Controlled substance medication such as Methylphenidate, **MUST** be brought to the school by the parent, counted, and recorded on the Medication Inventory for Controlled Drugs with the school nurse or school staff member;

E. When your child needs specialized medication such as: nebulizer treatment, inhaler, Epi-pen, or diabetes management, notify Office of School Health IMMEDIATELY, there are special forms that you need to take to the authorized prescriber. These forms can be obtained at your school or on the school system website www.pgcps.org;

F. Self-carry/self-administration of emergency medication MUST be authorized by the prescriber **and** supported by the school nurse's assessment. The school nurse's assessment is to determine appropriate capability of safely carrying emergency medication and devise an appropriate plan to assure safe medication administration in school.

G. For field trips parents MUST provide:

   A Prescriber's Medication Order Form **and** medication(s) for all prescription and/or non-prescription medications (not administered at school) to the nurse properly labeled at least thirty days prior to field trips.

Prince George's County Public Schools
Prescriber's Medication Order Form
Prescription and Non-Prescription Medication
ONE medication per form

ONLY for school year (current)

Name of School: _____

FOR COMPLETION BY PARENT(S)/GUARDIAN(S):

Student Full Name: _____ Date of Birth: _____ Grade: _____

Known Allergies: ☐ None ☐ Yes Specify: _____

_____

- I hereby authorize the medication described below to be administered as directed by my child's health care prescriber.
- I understand that the prescriber will be called if a question arises about my child's medication as allowed by HIPAA.
- I understand that ALL medications must be labeled with the name of the medication, name of the student, name of the prescriber, date, and directions for administration and prescription medication(s) must be labeled by a registered pharmacist.
- I understand that I must supply the school with the equipment/supplies needed to administer the medication.
- I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.
- I understand 911 will be called immediately if a medical condition warrants it.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

FOR COMPLETION BY PRESCRIBER

Medication Name: _____ Dose: _____ Route: _____

Reason for medication: _____

Time of medication is to be given: _____ Frequency: _____

If PRN, for what symptoms: _____

Side effects: _____

Special Instructions: _____

Date medication began (mo/day/yr): _____ Date medication discontinued (mo/day/yr): _____

Prescriber's Name/Title (print): _____

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____

(Original Signature or signature stamp only)

Order reviewed by RN/LPN: _____ Date: _____