STUDENT NAME: _____ SCIENCE TEACHER: _____

Newport Mill Middle School
Outdoor Education Program
Session 1 May 16 – 18, 2016

The MCPS Sixth Grade Outdoor Education program is an exciting three-day, two-night learning experience beyond the classroom walls.

FORMS DUE BY April 22nd, 2016

PARENT/GUARDIAN CHECK LIST

- **My child WILL attend NMMS Outdoor Education.**
- **My child WILL NOT attend NMMS Outdoor Education.** Please check off why below and turn in this form. (We MUST have this form from EVERY student.)
  My child will not attend NMMS Outdoor Education because:
  - He/She is not interested in attending the Outdoor Education program.
  - Financial reasons. (We offer financial assistance for your child to attend for FREE!)
  - Medical concerns.
  - The program involves staying overnight.
  - Other: _____
- **Complete Financial Obligation, Emergency Contacts, Pick-Up Procedure, and Liability/Waiver Agreement on front and reverse of this page.**
- **Complete "Outdoor Education Program Parent Permission" form.**
- **Complete "Authorization to Administer Prescribed Medication" form.**
- **Mark calendar with Parent/Guardian Informational Meeting dates and times.**

FINANCIAL OBLIGATION

- Cost of Outdoor Education program is $80.00. This fee includes meals, lodging for two nights, on-site nurse, activity supplies. (Please make any check payable to Newport Mill Middle School. Write the full name of your child in the memo section of the check.)
- Financial assistance is available so that every child is able to attend this program.

Please select one of the following payment options for NMMS Outdoor Education:

- I would like to make **one** full payment of $80.
- I would like to pay the $80 in **multiple** installments.
- I cannot pay the full $80, but I do not want my child to miss this amazing program. I am interested in **financial assistance**.

STUDENT NAME: _____ SCIENCE TEACHER: _____

EMERGENCY CONTACTS

Parent/Guardian 1: _____

Home: _____ Work: _____ Cell: _____

Parent/Guardian 2: _____

Home: _____ Work: _____ Cell: _____

Additional Emergency Contact: _____

Home: _____ Work: _____ Cell: _____

PICK-UP PROCEDURE

Upon returning from the Smith Center at 12:45 p.m. on May 18th (for session 1) or May 20th (for session 2), my child will get home by the following means:

- A parent/guardian will pick him/her up at 12:45 p.m.
- My child will ride home with _____

PLEASE REMEMBER: NO CHILD WILL BE ALLOWED TO WAIT FOR HIS/HER REGULAR SCHOOL BUS OR FOR HIS/HER FRIENDS/SIBLINGS TO BE DISMISSED AT 3:00.

LIABILITY/WAIVER AGREEMENT

I hereby release any Newport Mill Middle School staff from any liability for any personal injury or damage resulting from the transportation of my son/daughter from Outdoor Education in conjunction with a verbal agreement from the parent or guardian of that student.

Parent/Guardian Signature_____Date: _____

FORMS DUE BY April 22nd, 2016

Questions? Contact Jaclyn Pollock, Susie Reff or Jessica Snyder at 301-929-2244

Office of Curriculum and Instructional Programs
MONTGOMERYCOUNTYPUBUCSCHOOLS
Rockville, Maryland 20850

OUTDOOR EDUCATION PROGRAM
PARENT PERMISSION

INSTRUCTIONS TO THE PARENT/GUARDIAN: Please complete this form and return it to the teacher. The teacher will deliver the completed form to the health assistant or nurse upon arrival at the outdoor education center

Student's Name _____ D Male D Female

Address _____ Birth Date ____!___/____

School Name _____

Please check all that apply:

O My child needs medication. (Parent is required to furnish medication in the original properly labeled container, correctly authorized on MCPS Form 525-13: *Authorization to Administer Prescribed Medication.* No medicine will be given that is not in compliance with MCPS Policy JPC: *Administration of Medication to Pupils.*

D My child should take the following over-the-counter medications _____ . I have submitted MCPS Form 525-13. (A doctor's signature is **not** required for over-the-counter medications at the outdoor education program **only.)**

D My child is allergic to insect bites to the extent that he/she needs medical treatment. (If adrenalin is required, attach MCPS Form 525-14: *Emergency Care for Management of Anaphylaxis.)*

D My child has an anaphylactic reaction to _____ food(s). Attach MCPS Form 525-14 if adrenalin is required.

D My child is allergic to _____

D My child has special dietary requirements _____ . (Some special diets will require that parents supply some food.)

D My child has other special conditions of which you should be aware. They are: _____

_____

Date of student's last Tetanus shot___!____!___

INSURANCE INFORMATION

Medical Insurance Carrier's Name _____

Group/Organization _____

Policy Number _____

If Family is member of HMOIPPA:

Name of Group _____

Office Used I.D.#

Telephone# - -

OTHER INFORMATION

Name of Family Doctor _____

Doctor's Telephone # - -_____

Parent's/Guardian's Home Telephone #

_____ -_____

Female Head of Household **Work** and **Cell** Phone #

- - - -

Male Head of Household **Work** and **Cell** Phone #

- - _____ - ____-

Emergency Contact Name _____

Emergency Contact Phone # - -_____

D Check if your child is serving as a high school student assistant and list his/her school

I give permission for my child to participate in the outdoor education program described in the accompanying letter which I have read. In the event I cannot be reached in an emergency, I hereby give permission to the staff of the outdoor education center to secure proper treatment for my child.

_____ ____j____j__

Signature, Parent/Guardian *Date*

MCPS Form 345-7, Rev. 1/08

Office of Curriculum and Instructional Programming
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland 20850

AUTORIZACION DE LOS PADRES/GUARDIAN PARA EL PROGRAMA DE EDUCACION AL AIRE LIBRE

OUTDOOR EDUCATION PROGRAM PARENT PERMISSION- SPANISH

INSTRUCCIONES PARA LOS PADRES: Par favor complete este formulario y devuelvaselo a la maestra. La maestra entregara el formulario al asistente de salud o a la enfermera al llegar al centro de educaci6n al aire libre.

Nombre del Estudiante
Student's Name _____

D Masculino Male D Femenino **Female**

Domicilio
Address _____

Fecha de Nacimiento
Birth Date ____/____/____

Nombre de la Escuela
School Name _____

Par favor marque todo lo que aplique.

D Mi hijo/a necesita medicamento. (Se requiere que los padres faciliten el medicamento en su envase original, con el r6tulo que identifique al mismo y correctamente autorizado en el formulario MCPS Form 525-13: Authorization to Administer Prescribed Medication (Autorizaci6n Para Administrar Medicamento de Receta Medica). Nose administrara ningun medicamento que no este en cumplimiento con MCPS Policy JPC: Administration of Medication to Pupils (Politica JPC: Administraci6n de Medicamento a Estudiantes).
My child needs medication.

D Mi hijo/a debe tamar los siguientes medicamentos de venta libre.
My child should take the following over-the-counter medications _____
He suministrado el formulario MCPS Form 525-13 **(no se requiere** la firma de un medico para medicamentos de venta libre en el programa de educaci6n al aire libre **solamente).**

D Mi hijo/a es alergico/a a las picaduras de insectos hasta el punta de necesitar atenci6n medica.
My child is allergic to insect bites to the extent that he/she needs medical treatment.
(Si se requiere adrenalina, adjunte el formulario MCPS Form 525-14: Emergency Care for Management of Anaphylaxis (Cuidados de Emergencia Para Control de Anafilaxis).)

D Mi hijo/a tiene una reacci6n anafilactica a ciertos alimentos.
My child has an anaphylactic reaction to food(s) _____
Adjunte el formulario MCPS Form 525-14, si se requiere adrenalina.

[ ] Mi hijo/a es alergico/a a
My child is allergic to _____

[ ] Mi hijo/a necesita una dieta especial
My child has special dietary requirements _____
(Aigunas dietas especiales requeriran que los padres faciliten algunos alimentos.)

D Mi hijo/a tiene otras condiciones especiales que seria importante que usted conozca.
My child has other special conditions of which you should be aware. _____

_____

Fecha de la ultima vacuna contra el Tetano
Date of student's last Tetanus shot ____/____/____

OTRA INFORMACION
OTHER INFORMATION

Nombre del Medico de la Familia
Name of Family Doctor _____

Telefono del Medico
Doctor's Telephone # ___-___-____

Telefono de la Casa de los Padres
Parent's Home Telephone # ___-___-____

Telefono del Trabajo de la Madre
Mother's Work Telephone # ___-___-____

Telefono del Trabajo del Padre
Father's Work Telephone # ___-___-____

Nombre del Contacto en Caso de Emergencia
Emergency Contact Name _____

Telefono del Contacto en Caso de E::mergencia
Emergency Contact Telephone# ___-___-____

INFORMACION SOBRE EL SEGURO MEDICO
INSURANCE INFORMATION

Nombre de la Campania de Segura Medico
Medical Insurance Carrier's Name _____

Grupo/Organizaci6n
Group/Organization _____

Numero de P61iza
Policy Number _____

Si la Familia es Miembro de un Plan Medico HMOIPPA
If Family Is member of HMOIPPA

Nombre de Grupo
Name of Group _____

Oficina Utilizada
Oflice Used _____

Numero de Identificaci6n D.# _____

Numero de Telefono
Telephone# ___-___-____

D Marque si su hijo/a es estudiante asistente de una escuela secundaria en el programa de educaci6n al aire libre y escriba el nombre de su escuela.
Check if your child is serving as a high school student assistant and list h1s!her school

Autorizo a mi hijo/a a participar en el programa de educaci6n al aire libre descrito en la carta adjunta que ya he leido. En caso de que nose puedan comunicar conmigo en una emergencia, autorizo al personal del centro de educaci6n al aire libre a que administren el tratamiento adecuado para mi hijo/a.
I give pennission for my child to participate in the outdoor education program described in the accompanying letter which I have read. In the event I cannot be reached in an emergency, I hereby give pennission to the staff oilhe outdoor education center to secure proper treatment lor my child

_____ _____
Firma, Padre/Guardian/s,gnature. Parent!Guard1an Fecha Dote

MONTGOMERY COUNTY PUBLIC SCHOOLS
MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
Rockville, Maryland 20850

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION
Release and Indemnification Agreement

PART I-TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Montgomery County Public Schools (MCPS) and Montgomery County Department of Health and Human Services (MCDHHS) personnel to administer prescribed medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless MCPS and MCDHHS and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided MCPS and MCDHHS staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back of this form and assuj'Tle the responsibilities as required.

Student: _____ Birthdate: ____J__J____ School: _____

Prescription: O Renewal O New If new, the first full day's dosage was given at home on: ___; ___;___

List all medication(s) student is taking, including over-the-counter medication(s): _____

_____

_____ _____ _____
Parent/Guardian Signature *Phone Number* *Date*

PART 11-TO BE COMPLETED BY THE PHYSICIAN

The Montgomery County Department of Health and Human Services and the Montgomery County Public Schools discourage the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before and after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the back of this form.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ Diagnosis: _____
Trade name and/or generic

Dosage: _____ Time(s) To Be Given At School: _____
Ranges not accepted (i.e. 7 to 2 tabs or 2 to 4 puffs)

Route of Administration: _____ Effective Dates: From ___; ___ ; _To__J___J___

Side Effects:

If PRN, specify:

When indicated (signs/symptoms) _____

Frequency of administration _____
Ranges not accepted (i.e. every 2 to 4 hours)

_____ _____ _____ _____ _____
Physician's Name (print/type) *Physician Signature* *Phone Number* *Date*

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication such as inhalers and EpiPens® **must** be authorized by the prescriber and be approved by the school nurse according to the State medication policy:

Prescriber's authorization for self-carry/self-administration of emergency medication _____ ___J___J___
Signature *Date*

School Registered Nurse (RN) approval for self-carry/self-administration of emergency medication _____ ___f___f___
Signature *Date*

PART III-TO BE COMPLETED BY THE PRINCIPAL OR SCHOOL NURSE

Check as appropriate:

O Parts I and II above are completed, including signatures. (It is acceptable if all items of information in Part II are written on the physician's stationery/prescription blank.)

O Prescription medication is properly labeled by a pharmacist.

O Medication label and physician order are consistent.

O Over-the-counter medication is in an original container with the manufacturer's dosage label and safety seal intact.

__J___f___Date any unused medication is to be collected by the parent or guardian (within one week after expiration of the physician's order).

_____ ___f___f___
Principal/School Nurse Signature *Date*

INFORMATION AND PROCEDURES

1. No medication will be administered in school or during school-sponsored activities without the parent's! guardian's written authorization and a written physician order. This includes both prescription and over-the-counter (OTC) medications.
2. The parent/guardian is responsible for completing Part I and obtaining the physician's statement on Part II. This is required every school year for each new or continuing order or if there is a change in dosage or time of administration during the school year. (A physician may use offrte stationery or prescription pad in lieu of completing Part II.) Information necessary includes: child's name, diagnosis, medication name, dosage, time of administration, duration of medication, side effects, physician signature, and date.
3. The medication must be delivered to the school by the parent/guardian or, under special circumstances, an adult designated by the parent/guardian. Under no circumstances will either the school health (MCDHHS) or school (MCPS) personnel administer medication brought to school by the student.
4. All prescription medication must be provided in a container with the pharmacist's label attached. Non-prescription OTC medication must be in the container with the manufacturer's original label. Physician samples must be appropriately labeled by the physician.
5. The first day's dosage of any new medication must have been given at home before it can be administered at school.
6. The parent/guardian is responsible for collecting any unused portion of a medication within one week after expiration of the physician's order or at the end of the school year. Medication not claimed within that time period will be destroyed.
7. Self-administered and/or non-medically prescribed medications are entirely the responsibility of the parent/guardian and not that of either the Montgomery County Public Schools or Montgomery County Department of Health and Human Services. Medications without accompanying physician's orders and parental consent will not be stored in the health room.
8. Students may not self-adm inister controlled substances.
9. A physician's order and parental permission are necessary for self-carry/self-administered emergency medications such as inhalers for asthma and EpiPens for anaphylaxis. The school nurse must evaluate and approve the student's ability and capability to self-administer medication. It is imperative the student understands the necessity for reporting to either the health staff or MCPS staff that they have self-administered their inhaler without any improvement or have self-administered an EpiPen, so 911 may be called.
10. The school registered nurse (RN) will call the prescriber, as allowed by *Health Insurance Portability and Accountability Act* (HIPAA), if a question arises about the child and/or the child's medication.

Newport Mill Middle School
Outdoor Education Program
Session 1 May 16 – 18, 2016

GENERAL INFORMATION

PARENT/GUARDIAN INFORMATIONAL MEETINGS

- **January 13, 2016**: 8:00am and 6:30pm @ NMMS Media Center
- **March 16, 2016**: 6:30pm @ NMMS Media Center

FINANCIAL OBLIGATION

- Cost of Outdoor Education program is $80.00. This fee includes meals, lodging for two nights, on-site nurse, activity supplies. (Please make any check payable to Newport Mill Middle School. Write the full name of your child in the memo section of the check.)
- Financial assistance is available so that every child is able to attend this program.

MEDICATIONS

- **All medications**, including aspirin, vitamins, and cough medicine, to be administered at outdoor education must be accompanied by the MCPS Form 525-13 "Authorization to Administer Prescribed Medication to an MCPS Pupil While in School".
  - **Prescription medicine** should be in the original container with the pharmacy label. The medicine container should be labeled with the child's name and Outdoor Ed session.
  - **Over-the-counter** medication should be in an unopened container. Parents must bring their children's medication and form 525-13 to the Newport Mill Middle School nurse prior to departure, labeled with the child's name. The medications will be stored and administered in the health room at Smith Center. Medication must be picked up by the parent in the Newport Mill health room at the conclusion of the outdoor education program.
- **PLEASE NOTE: Medication must be hand delivered to the NMMS Health Room by an ADULT! Student CANNOT deliver medications.**

DIETARY RESTRICTIONS

If your child requires a special diet for religious or medical reasons, please send dietary instructions with your permission slips. **In extreme cases, parents will be asked to send pre-prepared meals for their children's individual needs**.

WEATHER

Outdoor activities will be held in wet or cold conditions and students must be prepared with appropriate clothing.

LOCATION:

Lathrop E. Smith Environmental Education Center 5110 Meadowside Lane, Rockville, MD 20855