

Clovis High School

Senior Activities - Parent Permission Slip BUS #_____

Student must bring permission slip & payment to sign-up for trip.

Initial Grad Night sign-up February 2, 2023 – March 20, 2023.

_____ has my permission to attend the following:

Grad Night is on **Friday, June 2nd** at Disneyland's California Adventure. Students will meet in the **South Gym** at **12:00 PM**. The buses will be leaving at **approximately 1 PM** from the access road and return by approximately 7:00 AM on **Saturday, June 3rd**. Seats are sold first come first come serve; seats may sell out prior to trip, in that event there will not be another bus ordered. **Once a student signs up on a bus, there are absolutely no bus changes. Students must be in CUSD Dress Code as well as Disney's Dress Code.**

Checks must be made payable to Clovis Unified School District in the amount of \$215.00.

Students must have their money (check, cash, money order), student ID, and signed permission slip in hand to sign up. Debit and Credit cards can be used in the Finance Office. Students who are not in good standing (Academic, Behavior, Financial) are at risk of not attending Grad Nite on Friday, June 2nd, 2023.

In the event that an issue with your student results in removal from the park, parents/guardians will be responsible for picking up and transporting their student home.

No refunds will be given unless approved by Clovis High School Administration. Buses and park tickets are pre-paid by Clovis High School.

Signature – Parent or Guardian

Home Phone & Cell Phone

In case of emergency and parent(s) cannot be reached, please contact:

Emergency Contact

Home Phone & Cell Phone

Student Cell Phone



PARTICIPATION IN VOLUNTARY FIELD TRIP
FORM 3204-1

CONSENT, ASSUMPTION OF RISK AND EMERGENCY MEDICAL AUTHORIZATION

(This form must be completed for participation in all field trips conducted by the CUSD)

The following voluntary field trip has been authorized by (school): Clovis High School

Overnight Trip: [X] Yes [] No Out-of-State Trip: [] Yes [] No

Specific Location: Disneyland's California Adventure

Description of Field Trip: Grad Nite

Day(s)/Date(s): 6/2/23 Departure: 1:00 AM/PM Return: 7:00 AM/PM

School Person in Charge: Sally Kirchner Position: Activities Director

LUNCH

- [] Student will be at school during lunch
[] Participant should bring sack lunch/drink*
[X] Other Only factory sealed items are allowed on trip

METHOD OF TRANSPORTATION

- [] Walking [] Private Vehicle
[] School Bus [X] Charter Bus
[] Airplane (commercial) [] Other

*See Authorization section

**Parent/Guardian Permission for Transporting Student in Private Vehicle is included.

A field trip fee (covering direct costs) in the amount of \$ 215.00 will be collected.

The participant may be exposed to the following high risk activities during this field trip/activity:
None will have staff chaperones at all times.

AUTHORIZATION: (Please return this form to the school person in charge listed above)

Participant Name: [X] Minor Student [] Adult Student [] Volunteer/Chaperone

I hereby authorize the above-named individual to participate in the field trip outlined above.

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and transportation considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services. I further acknowledge that the District does not provide medical coverage for participants in this activity.

I fully understand that participants are to abide by all rules and regulations governing conduct.

- [] I acknowledge that although the field trip may not be considered a high-risk activity, participants may be exposed to the high-risk activity(ies) listed above during this trip.
[] Special instructions regarding emergency medical treatment for the above-named individual are on file in the school office. (Please refer to the Emergency Card located in the school office.)
[] *IF APPLICABLE: I need Campus Catering to provide a sack lunch for the above-named participant. (Students will be charged according to their status in the National School Lunch Program. Other participants will be charged the full amount.)
[] I wish to volunteer as a chaperone and understand that I must also complete Form 9212-1, Volunteer Application, and meet the requirements of Board Policy No. 9212.
[] I have read and completed the waiver on Page 2.

Approval Signature (Parent or Guardian/Adult Student/Volunteer) Printed Name Date

Medical Insurance Carrier (i.e., Blue Cross, Kaiser): Policy Number:

Printed Name of Emergency Contact Relationship to Participant Phone Number

Other Phone Number Other Contact Person Phone Number

PARTICIPATION IN VOLUNTARY FIELD TRIP
FORM 3204-1 (continued)

WAIVER OF CLAIMS

All adults and adult students taking part in a field trip and all parents/guardians of minor students taking field trips are required to sign a statement waiving such claims.

Waiver by Parent/Guardian of Minor Student

I certify that I am the parent/guardian of the student identified below. As provided for in California Education Code Section 35330, I agree to waive all claims against the Clovis Unified School District (District) and hold the District, its officers, agents and employees harmless from any and all liability or claims which may arise out of or in connection with my child's participation in this activity. This waiver shall not apply to any occurrences which may arise solely out of the negligence of the District, its employees or agents.

Student Name: _____

Parent/Guardian Signature: _____ Date: _____

Waiver by Adult Student

As provided for in California Education Code Section 35330, I agree to waive all claims against the Clovis Unified School District (District) and hold the District, its officers, agents and employees, harmless from any and all liability or claims, which may arise out of or in connection with my participation in this activity. This waiver shall not apply to any occurrences which may arise solely out of the negligence of the District, its employees or agents.

Printed Name: _____

Signature: _____ Date: _____

Medical Authorization and Waiver by Adult Accompanying Student on Trip (Volunteer/Chaperone)

As provided for in California Education Code Section 35330, I agree to waive all claims against the Clovis Unified School District (District) and hold the District, its officers, agents and employees, harmless from any and all liability or claims, which may arise out of or in connection with my participation in this activity. This waiver shall not apply to any occurrences which may arise solely out of the negligence of the District, its employees or agents.

In the event of illness or injury, I hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and transportation considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services. It is understood that the resulting expenses will be the responsibility of the participant.

Special medical instructions, if any: _____

Printed Name: _____

Signature: _____ Date: _____

MEDICATION FOR STUDENT TRIPS/OFF-CAMPUS ACTIVITIES

Student's Name _____ Birthdate _____

Parent/Guardian Name _____

Dear Parent/Guardian/Physician:

California Education Code, Section 49423 defines certain requirements for administration of medication "... any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) **a written statement from such physician detailing the method, amount, and time schedules by which medication is to be taken, and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.**" CUSD Board Policy No. 2401 does not allow students to administer their own medication without written permission as stated above.

Additionally, CUSD Administrative Regulation No. 2401 indicates that school personnel are **prohibited** from administering any over-the-counter or prescription medications including aspirins, vitamins, antihistamines, etc. unless the medication is accompanied with **written permission from both the parent/guardian and physician.** The medication **must be** clearly labeled and sent to school in a container from the pharmacy and **will be kept in the school office unless otherwise directed by the physician.**

At the beginning of each school year or upon entry into school, a "MEDICATION AT SCHOOL" form must be **completely renewed.**

If you require any additional information regarding the above, please contact me at:
 _____ 327-1401 (phone) OR _____ 327-1449 (fax)

School Nurse Ellen Gates, RN _____ Date _____

PARENT/GUARDIAN REQUEST

We, the undersigned, who are the parents/guardian of _____ request that the school nurse or designated school personnel assist our child in the matter set forth by the physician's statement. In the event of an untoward or subsequent reaction, it is understood that the school personnel will in no way be held responsible for carrying out this request.

Signature of Parent/Guardian _____ Date _____

PHYSICIAN MUST COMPLETE THE REVERSE SIDE OF THIS FORM
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PHYSICIAN'S ORDERS

Student's Name _____

1. Medication is needed for the following reason(s): _____

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>TIMES TO BE GIVEN</u>

2. Time limit on medication (i.e., 10 days, 1 month, etc.): _____

3. Student may carry inhaler on his/her person Yes____ No____

PERMISSION TO GIVE OVER-THE-COUNTER MEDICATION

During school trips and/or when student is participating in an off-campus activity, he/she may take the following:

<u>YES</u>	<u>NO</u>	<u>MEDICATION</u>	<u>DOSAGE</u>	<u>TIME(S) TO BE GIVEN</u>
<input type="checkbox"/>	<input type="checkbox"/>	Tylenol (325mg)	<u>2 tablets</u>	<u>every 4 hrs if needed for pain/fever</u>
<input type="checkbox"/>	<input type="checkbox"/>	Benadryl (25mg)	<u>1-2 tablets</u>	<u>every 4-6 hrs if needed for sneezing, itching, runny nose</u>
<input type="checkbox"/>	<input type="checkbox"/>	Tums	<u>1-2 tablets</u>	<u>for upset stomach, heartburn as needed</u>
<input type="checkbox"/>	<input type="checkbox"/>	Dramamine (50mg)	<u>1-2 tablets</u>	<u>every 4 hrs if needed for motion sickness</u>
<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen (200mg)	<u>1-2 tablets</u>	<u>every 4 hrs if needed for pain/fever</u>
<input type="checkbox"/>	<input type="checkbox"/>	Bacitracin Ointment	<u>As needed</u>	<u>1-3 times daily on affected areas</u>
<input type="checkbox"/>	<input type="checkbox"/>	Sudafed (30mg)	<u>1 tablet</u>	<u>every 4-6 hrs if needed for congestion</u>

Physician's Name (please print or type) _____

Physician's Signature _____ Date _____

Address _____ Phone _____

THANK YOU!