

MERCER ISLAND SCHOOL DISTRICT #400
Permission to Participate/Assumption of Risk
Extended and International Field Trips

For best results when filling out this form on your computer, download it first and open in Adobe Acrobat Reader

As a parent or guardian of a student requesting to voluntarily participate in a field trip, I hereby acknowledge that I have read, understood and agreed to the following:

Field Trip Destination: Wenatchee, WA Purpose: MHS Girls Swim / Dive Retreat

I hereby give my permission for: (Student's Name) who attends: MHS (School Name)

To participate in a field trip on (date): 8/26 - 8/27 Time involved: From: 11am 8/26 To: 7pm 8/27

Type of Transportation: School Bus, District Van driven by district staff, Train, Air, Marine Vessel, Charter Bus, Other (describe)

Student's Address: City: Parent's Phone: Home: Cell: Student Birthdate: Parent's Email (1): Parent's Email (2): Family Physician: Phone #: Insurance Provider: Insurance Number:

Medical conditions, medication information or allergies the District should be made aware of (write below):

In the event of an emergency, I wish the following person to be notified in case I cannot be contacted: Name: Phone #:

I understand that all school and district policies are in effect on this trip. I understand that this is a school sponsored activity and is governed by the Policies and Procedures of the Mercer Island School District. These rules are delineated in Board Policy 3241, accessible on the District's website.

I certify that my child has no medical or physical conditions which could interfere with his/her safety in this activity.

I authorize qualified emergency medical professionals to examine and in the event of injury or serious illness, administer emergency care to the above named student. I understand every effort will be made to contact me to explain the nature of the problem prior to any involved treatment.

In the event it becomes necessary for the school district staff-in-charge to obtain emergency care for my student, I understand that I am responsible for any costs associated with an accident or injury. My child has medical/ accident insurance: Yes No

HOLD HARMLESS

I acknowledge that this activity may entail known and unanticipated risks which could result in physical or emotional injury, paralysis or death, as well as damage to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity. I agree to hold and save harmless the Mercer Island School District, its School Board and Employees, and assigns for any claims, suits or damages (including but not limited to defense and indemnification) which might result from my child participating in the above-described event/activity.

Being fully informed as to these risks, I hereby consent to my child participating in this Field Trip.

Signature of Parent/Guardian Date Work/Daytime Phone

Adopted: 08/15/16

Mercer Island School District
4160 86th Avenue SE • Mercer Island, WA 98040

MEDICATION AUTHORIZATION FORM

For best results when filling out this form on your computer, download it first and open in Adobe Acrobat Reader

Student Name: _____ School: _____ Grade: _____ DOB: _____

Parent/Guardian: _____ Phone (Hm): _____ (Wk): _____

Mercer Island School District No. 400 is authorized by RCW 28A.210.260 State Statutes to administer any prescribed and over the counter medications to students during school hours, only when: 1) The medication is accompanied by a written, current, and unexpired request from a licensed medical health care provider, and 2) there exists a valid health reason that makes administration of the medication advisable during school hours.

Medication requests will be valid only for the medication(s) listed and the dates indicated on District request forms. Requests shall not extend beyond the end of the current school year. Medications must be supplied in their original container with the label indicating the student's name, the licensed medical health care provider's name, the dosage, and instructions for administration. Medication may be administered by non-licensed/non-medical school personnel.

When a parent/guardian, medical health care provider, and school nurse agree, a student may be allowed to carry and self-administer medication. (See MISD School Board Procedure #5139.2 for specific allowances).

For your convenience, Medication Requests may be faxed to: School Nurse: MIHS Fax # 206-236-3358; IMS Fax # 206-236-3408; Island Park Fax # 206-230-6251; Lakeridge Fax # 206-230-6232; Northwood Fax # 206-275-5889; West Mercer Fax # 206-230-6043

Medical Health Care Provider Request

Medication name and strength:	#1	#2	#3
Dosage (# of pills/tsp. etc.):	#1	#2	#3
Time of administration:	#1	#2	#3
Reason for administration:	#1	#2	#3
Side effects:	#1	#2	#3

Known medication allergies: _____

Other medications being taken by student: _____

As physician for this student, I agree he/she is capable of self-administration: Yes No

As physician for this student, I agree he/she may carry the above meds with him/her: Yes No

I request and authorize the administration of the above medication(s) for the period beginning _____ day of _____ 20____
through _____ day of _____ 20____ as there exists a valid health reason which makes administration of the medication
advisable during school hours.

Medical Health Care Provider Signature _____ Date _____

Type or Print name of Medical Health Care Provider _____ Phone _____ Fax _____

Parent/Guardian Request

I certify that I am the parent, legal guardian, or person in legal control of the above-named student. I request and authorize the Mercer Island School District to administer this medication to the above named student in accordance with the instructions of the authorizing student's medical health care provider above. I also authorize the District to enter into a Mutual Exchange of Information with the student's medical health care provider named above. I acknowledge receipt of the district's procedures for medication in the school.

If the medical health care provider, school nurse and principal agree, I also give permission for my child to self-administer this medication at school: Yes No

If the medical health care provider, school nurse and principal agree, I also give permission for my child to carry this medication at school: Yes No

Parent/Guardian Signature _____ Date _____

School Nurse Approval _____ Date _____