

TIVY H.S. CHOIR PROGRAM TRAVEL & HEALTH FORM

_____ (*Student Name*) has my permission to travel on all Tivy High School Choir functions for the **2023-2024** school year via Kerrville Independent School District transportation. I understand that I am releasing Kerrville Independent School District, its employees, staff, booster club, and / or consultant staff of any liability in case of injury during student travel. I also understand that my student must travel via K.I.S.D. transportation both to and from a performance event unless pre-approved written permission has been received by the Choir Director from a supervising administrator.

I hereby authorize any Kerrville I.S.D. employee to seek whatever medical attention may be necessary for my student if he/she becomes in need while participating with the Tivy H.S. Choir.

Parent/Guardian Signature

Date

Please Print Clearly

Address: _____

Phone: _____ Cell: _____

E-mail: _____

Emergency Contact Information

Name: _____

Phone Number(s): _____

Relationship: _____

Insurance Information (Please complete all information available)

Insurance Provider: _____

Insured / Subscriber Name: _____

Policy # / ID #: _____

Insurance Phone #: _____

Group #: _____ Network #: _____

Other

Student date of birth: _____

List any known medical conditions: _____

List any serious allergies: _____

List any prescriptions medications taken regularly: _____

KERRVILLE INDEPENDENT SCHOOL DISTRICT

REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

NAME OF STUDENT _____ **DOB** _____ **GRADE** _____

NAME OF MEDICATION _____

WHAT TIME IS MEDICINE TO BE GIVEN AT SCHOOL? _____

HOW MUCH MEDICINE IS TO BE GIVEN AT SCHOOL? _____

WHY IS MEDICINE BEING GIVEN? _____

1. Only FDA approved medications from the United States will be administered at school.
2. Medications must be in the original container and properly labeled.
3. Permission to Administer Medication Form must be completed and signed by parent or legal guardian. No verbal/phone consent will be accepted.
4. Medication will be kept in a secure location in the nurse's office during school hours.
5. All medication not used by the student must be picked up by the parent or guardian when no longer needed. Medications will not be delivered to a home.
6. Medications may be administered by the school nurse, clinic volunteers/substitutes who are licensed medical personnel or a school employee who is a medically untrained designee of the principal.

Parent's signature _____ Date _____

Date	Amount Received	Staff Signature	Parent Signature