

# TIVY H.S. CHOIR PROGRAM TRAVEL & HEALTH FORM

\_\_\_\_\_ (*Student Name*) has my permission to travel on all Tivy High School Choir functions for the **2024-2025** 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 \_\_\_\_\_

<b>Date</b>	<b>Amount Received</b>	<b>Staff Signature</b>	<b>Parent Signature</b>