To all 8th graders and parents:
Please read, discuss, sign and return ALL forms attached completely by Friday, November 15, 2024. The forms can be returned to either Mrs. Baitala or Ms. Loll.
** Please make a copy of the front and back of your current health insurance card and attach to the Medical Information/Medication Permission form**

Any questions, please email me at:
HeatherLoll@parkridge.k12.nj.us

There will be a nurse and an administrator on the trip.

Thank you,

Ms. Heather Loll

PARK RIDGE BOARD OF EDUCATION

PERMISSION FOR TRAVEL AND RELEASE OF LIABILITY

SEPTEMBER 1, 2024 – AUGUST 31, 2025

Name of Student: _____ Grade: 8th Date of Birth:_____

I/We,_____, parent(s)/legal guardians(s) of_____, give permission for my/our child, _____, to participate in the travel excursion set forth below

Destination: Philadelphia, Pennsylvania **Mode of Transportation:** Charter Bus

Departure Date and Time: Thursday, May 1, 2025 7:30am **Purpose of Trip:** Educational

Return Date and Time: Friday May 2, 2025 ETA 4:15pm

I/We understand and agree that on this trip, my/our child is expected to follow all school rules and is expected to conduct him/herself in accordance with the expectations for student conduct as set forth in the Park Ridge Board of Education's (hereafter referred to as the Board) Policies and Regulations and/or Student Handbook, just as if my/our child were at school. I further understand that my child is expected to abide by the laws and regulations of the countries to which he/she travels.

I also understand that if my/our child fails to comport him/herself within such expected standards of behavior, he/she shall be subject to discipline as set forth in the Board's Policies and Regulations and/or Student Handbook, as well as possible criminal or civil charges by the authorities of the countries visited. Discipline imposed by the Park Ridge School District personnel or chaperones may include, but is not limited to, termination of my/our child's participation on the trip or restriction of my/our child's activities while on the trip. I understand that if my/our child's participation on the trip is terminated, I/we will be responsible for all expenses related to my/our child's early return home.

As part of granting this permission and release of liability, I/We agree to hold the Board completely harmless and indemnify the Board, its officers, agents, employees, and chaperones, from any and all liability, claims or suits of any kind whatsoever, of or relating to this trip and/or related transportation activities, or any other aspect of this trip. I/We further understand and agree that the Board is not responsible for any losses, damage, injuries, expenses, costs, claims or actions which my child may incur or cause as a result of participating on this trip. The Board is released from any and all liability for financial obligations incurred by my/our child or us and I/we agree to indemnify the Board, its officers, agents, employees, and chaperones with regard to such liabilities.

PARENT/GUARDIAN SIGNATURE

I agree to all of the provisions set forth above and verify that the information provided herein is accurate to the best of my knowledge.

_____ _____

Parent/Guardian or Adult Student Name Date

(please print)

_____ _____

Parent/Guardian or Adult Student Name (Signature) Date

Emergency Contact Information:

1. _____ _____ Home Phone:_____

   Name (please print) Relationship Cell Phone:_____

   Business Phone:_____

   Email:_____

2. _____ _____ Home Phone:_____

   Name (please print) Relationship Cell Phone:_____

   Business Phone:_____

   Email:_____

3. _____ _____ Home Phone:_____

   Name (please print) Relationship Cell Phone:_____

   Business Phone:_____

   Email:_____

Park Ridge Board of Education

Health History and Medical Release from Liability

Trip to_____ on_____

(location) (dates)

September 1, 2024 – August 31, 2025

STUDENT INFORMATION

Student's Name_____ Age:_____ Grade:_____

(please print)

Date of Birth:_____ School:_____

Address:_____

Phone (cell):_____ International Access? ___Yes or ___ No

EMERGENCY CONTACT INFORMATION

Name of parent(s)/guardian(s):_____

Address:_____

Phone (work):_____ Phone (home):_____

Phone (cell):_____ E-mail:_____

Additional emergency contact:_____

Relationship to student:_____

Phone (work):_____ Phone (home):_____

Phone (cell):_____ E-mail:_____

Student's Medical Insurance Carrier:_____ Telephone Number:_____

Student's Medical Insurance Identification Number:_____

I/We understand that the information provided below will be maintained throughout the duration of the above referenced trip by Park Ridge School District and the trip chaperones. In the event that a medical occurrence arises, this information will be shared with medical personnel, as necessary.

Date:_____ _____

Parent Name (please print)

_____

Parent Name Signature

PHYSICIAN INFORMATION

Physician's Name:_____

Physician's Address:_____

Physician's Telephone Number:_____

Physician's Fax Number: _____

Physician's E-mail:_____

Directions: Please answer the following questions about your child's health history by placing a "√" next to "yes" or "no." Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Has your child ever had or does your child currently have any of the following chronic illnesses:
   a. A chronic or ongoing illness (such as diabetes or asthma)?

      _____Yes ____No

      i. An inhaler or other prescription medicine to control asthma?

         _____Yes ____No

      ii. Any prescribed or over the counter medication to control asthma?

         _____Yes ____No

   b. Surgery, hospitalization or any emergency room visit(s)?
      _____Yes ____No

   c. Any allergies to medications?
      _____Yes ____No

   d. Any Allergies to bee stings, pollen, latex or foods?
      _____Yes ____No
      i. If yes, check type of reaction:

         ____Rash ____Hives

         ____Breathing or other anaphylactic Reaction

      ii. Medication/Epipen taken for allergy symptoms? (List below).

         ____Yes ____No

   e. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders?

      ____Yes____No____

Explain all "Yes" answers here (include relevant dates):

2,. Has your ever had or does your child currently have any of the following related conditions:

a. Concussion or head injury?

____Yes____No

b. A seizure?

____Yes____No

c. Frequent or severe headaches (with or without exercise)?

____Yes____No

d. Fuzzy or blurry vision

____Yes____No

e. Sensitivity to light/noise

____Yes____No

Explain all "Yes" answers here (include relevant dates):

3. Has your ever had or does your child currently have any of the following heart- related conditions

a. Chest pain or discomfort?

____Yes____No

b. Heart murmur?

____Yes____No

c. High blood pressure?

____Yes____No

d. Elevated cholesterol level?

____Yes____No

e. Heart infection?

____Yes____No

f. Racing or skipped heartbeats?

____Yes____No

g. Unexplained difficulty breathing or fatigue during exercise?

____Yes____No

Explain all "yes" answers here (include relevant dates):

_____
_____
_____
_____

4. Has your child ever had or does your child currently have, eye, ear, nose, and/or mouth conditions:

a. Vision problems?

____Yes____No

i. Wear contacts/eyeglasses? (Circle which type)

b. Hearing loss or problems?

i. Wear hearing aides/implants? (Circle which type)

c. Nasal fractures or frequent nose bleeds?

____Yes____No

d. Wear braces or retainer?

____Yes____No

Explain all "Yes" answers here (include relevant dates):

_____
_____
_____
_____

List all prescription and over the counter medications that your child takes and if they will be self-administered during the trip:

Medication Name	Dosage	Frequency	Self-Administered by your child During Trip Yes/No

MEDICAL RELEASE OF LIABILITY

A. Use of over the counter or prescription medications:

I/We understand that I must grant written permission for my/our child to self-administer any prescription or over the counter medications throughout the duration of the trip. I/We further give consent for the school nurse to contact my/our child's physician, discuss my/our child's schedule for the self-administration of medications, and discuss my child's medical status. All medications must be in the originating labeled container and I understand that my/our child is responsible for securely storing, transporting and self administering the medications throughout the duration of the trip. I/We hereby certify that my/our child is capable of and has been instructed in the proper method of self-administration of medication. I/We acknowledge that the Park Ridge Board of Education (hereinafter referred to as the "Board"), its officers, employees, agents or chaperones shall incur no liability as a result of any injury arising from my/our child's storage, transportation, or self-administration of prescription or over the counter medications and I/we shall indemnify and hold harmless the Board, its officers, employees, agents or chaperones against any and all claims arising out of the storage, transportation, or self-administration of such medications by my/our child. I/We certify that I/we have complied with the Board Policy and Procedures on the self administration of medication and have met the requirements of N.J.S.A. 18A:40-12.3.

_____ _____

Park Ridge Board of Education Administrator

(please print name and title)

Parent/Guardian or Adult Student Name (please print)

_____ _____

Park Ridge Board of Education Administrator Signature

Parent/Guardian or Adult Student Name Signature

_____ _____

Date

Date

B. Emergency Medical Treatment

I/We do hereby grant permission to the designated Board's staff and/or chaperones to whom we have entrusted the care of our child, to authorize necessary emergency medical or surgical treatment, anesthesia or any required diagnostic tests in the event that I/we cannot be contacted. I/We agree to assume any and all financial costs that these events may incur. I/We release the Park Ridge Board of Education (hereinafter referred to as the "Board") from any financial obligations incurred by me/us or my/our child and agree to hold harmless and indemnity the Board, its officers, employees, agents or chaperones from any and all liability arising out of any emergency medical or surgical treatment, anesthesia, or diagnostic testing that my/our child may receive.

Date:_____

_____

Parent/Guardian or Adult Student Name (please print)

_____

Parent/Guardian or Adult Student Name Signature

PARENT/GUARDIAN SIGNATURE

I certify that the information provided in the Health History and Medical Release form is accurate to the best of my knowledge.

_____ _____

Parent/Guardian or Adult Student Name (please print)

Date

_____

Parent/Guardian or Adult Student Name Signature