



Morristown Beard School

REQUIRED MBS HEALTH & MEDICAL SUPPLEMENTAL FORM

Participant: _____ Birthdate: _____
Address: _____ Telephone: _____
Doctor's Name(s): _____ Telephone: _____
Trip Name: _____

MBS will consult the school's medical records when a student participates in a trip. The following supplementary questions will help us understand any additional needs.

1. Please describe any **dietary restrictions**.

2. Rate and circle your child's **swimming** ability:

Level 1 – non-swimmer – cannot travel 50 yards

Level 2 – adequate swimmer - can travel 50 yards and stay afloat for 60 seconds, but does not put face in the water between each stroke or is unable to demonstrate proficiency in any competitive strokes.

Level 3 – proficient swimmer – can demonstrate proficiency in freestyle, i.e., put their face in the water and coordinate breathing between strokes.

Level 4 – competitive swimmer – demonstrates proficiency in freestyle and other competitive strokes and has been training with a swim team at some point during previous year.

3. Describe any **allergies** your child has (environmental, food, medicine).

4. Does your child suffer from physical limitations that will hamper your child's ability to perform the physical activities associated with the trip?

_____ YES _____ NO

5. Are there any medical, emotional, and/or psychological conditions that affect your child's ability to participate in this trip?

_____ YES _____ NO

If you answered "yes" to questions 4 or 5, please **describe any physical, medical, emotional, and/or psychological health conditions that** might limit your participation on the trip. These may include, but are not limited to: seizures, eating disorders, ADD/ADHD, anger management, claustrophobia, fear of flying (or other anxiety), asthma/difficulty breathing, or difficulty with altitude, heat, or humidity. Having a limitation will not necessarily disqualify a participant from attending the trip, but chaperones need to know how to better ensure the health and safety of their child. MBS is not responsible for any injury, illness, inability to participate, or loss of monetary value or experience that occurs as a result of a medical/health condition not disclosed to the school.

In order to participate in overnight/international trips, where the daily structure, student resources, and supervision are more limited than the on-campus school day, any student who meets the following criteria will need to have their travel plans supported by their care team and the School.

- receiving short-term accommodations for mental health support
- has been recently hospitalized
- is engaged in school-required therapeutic support
- is otherwise engaged in a modified program

In addition, a letter from the student's care team endorsing their participation in the trip will be required.

Some items to consider in preparation for travel:

If your child is being treated for a medical condition or mental health issue, discussing your intent to allow your child to travel with your child's treatment provider is important.

Allergies: If your child has a life-threatening allergy, this must be listed on the previous page under "allergies." In addition, a doctor's note will be needed to participate in the trip.

Prescription medication: If your child is taking a prescription medication, send an adequate supply and complete the corresponding medication form.

I certify that to the best of my knowledge, my child is able to participate in all of the trip's activities. I have disclosed any and all health issues that could affect his/her/their participation in this trip.

I intend to participate in all activities except as noted above.

Participant Name Printed: _____

Participant Signature: _____

Date: _____

If the participant is under 18 years of age:

Parent Name printed: _____

Parent Signature: _____

Date: _____

MBS Trip Parent/Legal Guardian Release Form

Parents'/Legal Guardians' Authorization, Indemnification, and Medical Treatment Agreement

Morristown Beard School ("MBS") Trip to Washington D.C. will take place April 9-11, 2025. This Release Form affirms that you agree that (1) your child is permitted to participate in this field trip as well as all activities taking place during the field trip, (2) your child is permitted to travel with MBS chaperones, (3) you agree to the risks associated with this field trip; (4) you authorize MBS, its employees, and chaperones to obtain emergency medical care for your child, should such care become necessary during the course of the trip; and (5) you and your child have reviewed the necessary travel health precautions associated with the location of the trip with a trained medical professional.

Please read the language of the below provisions carefully and ask questions if necessary. **Your child will not be able to participate on this trip without the completion and notarization (International travel only) of this form.**

1. Parental Permission to Participate:

As the custodial parent(s)/guardian(s) of _____ (please print student's name), grade _____ (provide the child's grade) from MBS, I have given my child my permission to participate in the bus trip to Washington D.C. from Morristown Beard School. I am familiar with the mental and physical health of my child and my child's ability to travel to unfamiliar places and be exposed to people of different ethnic, cultural, and linguistic backgrounds. My permission for my child to participate is based upon my belief that my child has the maturity and self-confidence to be able to participate appropriately in the activities students will encounter during the Washington D.C. trip as they have been described in the printed materials that I have been given.

I also authorize my child to travel with the trip chaperones and faculty members of MBS. This trip will depart from Morristown Beard School on April 9, 2025 at 7:30am and drive to Washington D.C. My child will be traveling in Washington D.C., and will return to Morristown Beard School on April 11, 2025 around approximately 8:00pm.

Print Full Name of Parent/Guardian #1 _____
Parent/Guardian Signature _____ **Date** _____

Print Full Name of Parent/Guardian #2 _____
Parent/Guardian Signature _____ **Date** _____

2. COVID-19 Testing and Screening

In the event my child exhibits symptoms of COVID-19 during the Trip, I understand that my child will be required to undergo a COVID-19 test while on the Trip. I consent to MBS and/or a trained third-party administering this COVID-19 test for purposes of my child's continued participation in

the trip. I further release MBS, its employees, agents, officers and representatives, from any and all claims arising out of or related to the administration of the COVID-19 testing unless such claim is a result of willful misconduct by MBS.

I understand that if my child tests positive for COVID-19 prior to the Trip and is subject to quarantine on the date of departure as a result, my child will not be permitted to participate in the trip.

I agree that if my child has a fever of over 100 degrees on the day of the Trip or is exhibiting any symptoms of COVID-19 including difficulty breathing, sore throat, cough, runny nose, or loss of taste and/or smell, that I am required to report this to MBS and that my child will not be permitted to participate in this Trip.

3. Parental/Legal Guardian Release, Hold Harmless, and Indemnification Agreement:

I recognize that there are inherent risks to my child's person and property involved in air travel, surface transport, in staying at hotels, dorms, and/or with local families, and in participating in activities in an unfamiliar country.

I agree to independently and carefully review the links to websites for organizations such as the Centers for Disease Control and Prevention and the State Department. I agree to review the relevant information contained in those websites, in addition to any other safety information provided by MBS. I understand that the safety guidelines are designed to protect my child, and hereby accept sole responsibility for any failure of my child to comply with same. I agree that I am responsible for providing my child with the necessary goods and materials in furtherance of ensuring my child's safety during the trip.

I understand that the sponsorship of field trips is a positive activity that benefits the participating students and their families. In consideration for the benefits which my child will derive from these activities, I hereby agree to release and hold harmless, on behalf my child, myself and all of my heirs and legal representatives, MBS, its trustees, officers, agents, employees, chaperones and volunteers from and against any and all liability or claims of any nature, including, but not limited to, personal injury, wrongful death or property damage or loss, that may result from, arise out of, or in connection with the planning, operation, participation in, and supervision of the trip and any related transportation and travel.

I have reviewed the plans for the bus trip to Washington D.C. from Morristown Beard School and recognize that use of regularly scheduled airlines or other vehicles to provide transportation between our school and Washington D.C. involves risks to person and property, which may include serious injury/illness and death, and I agree to accept those risks. From my review of the plans for the Washington D.C. trip I am aware that my child will also be exposed to the risks of surface travel in buses, vans, and personal vehicles while participating in activities, and I accept the responsibility for those risks. I have reviewed the arrangements for the trip and understand that my child will be staying with other MBS students and chaperones in a local hotel, and I accept the risk that injury may occur to my child while staying in Washington D.C.. I have also reviewed the description of the daily activities that will take place during the trip and recognize that participating in those activities in Washington D.C. will expose my child to the risks inherent in those activities, and I am willing to accept responsibility for those risks.

I have read all of this COVID-19 Testing and Screening as well as the Parental Release, Hold Harmless, and Indemnification Agreement, and I have satisfied myself that I understand what it means.

Print Full Name of Parent/Guardian #1 _____

Parent/Guardian Signature _____ **Date** _____

Print Full Name of Parent/Guardian #2 _____

Parent/Guardian Signature _____ **Date** _____

3a. Medical Treatment Authorization:

I am aware that no medical personnel will be attending the trip. I hereby authorize MBS employees, representatives, and chaperones to act on my behalf during this trip to examine and, in the event of injury or serious illness, administer emergency care to my child. I understand that reasonable effort will be made to contact me to explain the nature of the problem prior to any medical treatment. Specifically, but without limitation, I hereby authorize the MBS employees, representatives, and chaperones to transport my child to a hospital or doctor's office in an emergency situation where this is deemed necessary. In the event that it becomes necessary to obtain emergency care for my child, neither MBS, its employees, representatives or chaperones assume any financial liability for expenses incurred as a result of any accident, injury, illness and/or other unforeseen circumstance necessitating emergency care.

I further authorize physicians and/or other medical personnel to provide medical care to my child while he/she is away from home and participating in this trip, including examining, treating and prescribing medications for my child's care. I understand that the physicians and/or other medical personnel on location will, to the greatest extent possible, consult with me concerning the reasons for and effects of all such care.

Recognizing that it may be impossible to reach me in situations in which the physicians treating my child believe that beginning treatment is medically necessary, I authorize commencement of treatment when, in the professional judgment of the physicians and/or other medical personnel involved, such treatment is medically necessary, even if I have not yet been consulted. In such circumstances, I also authorize our family physician to release to emergency medical personnel any medical information deemed necessary at the time. In authorizing such emergency treatment, I agree to accept the determination of the treating physician or surgeon that the treatment or examination rendered was medically necessary to protect the life, health, or mental well-being of my child.

I accept responsibility for any and all medical or hospital expenses not covered by insurance that are incurred by my child in case of illness, accident or injury, during this trip.

3b. Travel Immunizations

I hereby confirm that I have taken the following steps in connection with my child's participation in the Washington D.C. bus trip.:

1. Reviewed the list of medical concerns for the country or regions to be visited maintained by the Centers for Disease Control and Prevention.
2. Reviewed with the following travel medicine clinic all necessary medical precautions that should be taken with respect to the country or regions my child will be visiting in connection with the trip. Please list the name of the treating physician and the location of his/her office:
3. Reviewed with our child all of the medical precautions recommended by such a clinic.

3c. Medications:

A nurse does not accompany the students on this trip. I acknowledge that I am responsible for ensuring my child has all medication required by my child on this trip. I understand my child is responsible for taking the medication as prescribed during the course of this trip.

Print Full Name of Parent/Guardian #1 _____

Parent/Guardian Signature _____ **Date** _____

Print Full Name of Parent/Guardian #2 _____

Parent/Guardian Signature _____ **Date** _____

MANDATORY MEDICATION FORM

MBS Mandatory Medication Form

ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT/LEGAL GUARDIAN and PHYSICIAN.

- **Prescription medication** must be delivered to the nurse by the parent/legal guardian in the original container, labeled with the student's name, medication, dosage, and physician's name.
- **Over-the-counter (OTC) medication** must be delivered to school by the parent/legal guardian in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/legal guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications that are medically necessary for a student's wellbeing during school hours or while on a school-sponsored trip should be sent to school.

NOTE: THE FIRST DOSE OF ANY MEDICATION MAY NOT BE GIVEN AT SCHOOL OR DURING A SCHOOL-SPONSORED TRIP/ACTIVITY.

LEGAL NAME OF STUDENT : _____

STUDENT'S DATE OF BIRTH: _____

FULL NAME OF MEDICATION: _____

DOSAGE: _____

TIME TO BE GIVEN: _____

REASON FOR MEDICATION: _____

MEDICATION TO BE GIVEN FROM _____ TO _____
Date Date

HOW THE MEDICATION IS TAKEN _____
Examples: by mouth, inhaler, with food, crushed, *etc.*

ADDITIONAL COMMENTS _____

Parent/Legal Guardian Signature/Date

Physician Signature/Date

Telephone Number of Parent/Legal Guardian

Telephone Number of Physician

MBS TRIPS: PARTICIPATION AGREEMENT BEHAVIORAL EXPECTATIONS

MBS Trip Behavior Contract Form

MBS trips offer tremendous opportunities, but also necessitate tremendous trust as we move student learning past the classroom and into settings that often require specialized practices and new routines.

The following constitute the rules and expectations for all MBS trips, with special emphasis on those that have off-campus or overnight components. Violations of any of these rules and/or expectations could result in loss of privileges, termination of a student's participation in a trip, and/or disciplinary consequences at school.

Each student and their parent(s)/legal guardians (s) must read and agree to the rules contained in this form.

Any student who commits a serious breach of the rules or continues to disregard any of the trip rules will be sent home. Any extra expense, including travel expenses for a chaperone, will be borne by the parent(s)/legal guardian(s) of the student. The school reserves the right to restrict a student's access to future MBS trips if a student fails to follow all rules and guidelines.

- 1) MBS trips are a school-sponsored program which means all school rules apply at all times. Please review the MBS Family Handbook for more information prior to signing this document.
- 2) Students must participate/take part in all planned group activities as assigned by the trip leaders and chaperones.
- 3) Students must obey all directives, rules, and safety precautions established by the trip leaders and chaperones.
- 4) Students are expected to take care of their personal belongings, including gear, money, equipment, and clothing. Trip leaders and chaperones cannot be held responsible if any personal items are lost, stolen, or misplaced during an MBS trip.
- 5) Mature, courteous, thoughtful behavior and conduct of the highest quality are expected throughout the duration of all trips. Students should be respectful of other participants and chaperones, responsible for being on time, and committed to taking full advantage of each phase of the trip or class experience.
- 6) Given the nature of MBS trips, there will be times when students may not be under direct adult supervision. Students are responsible for their actions, whether under direct supervision or not.

**MBS TRIPS: PARTICIPATION AGREEMENT
BEHAVIORAL EXPECTATIONS**

- 7) Maintaining inclusive group dynamics are essential to the integrity of MBS trips. Students are expected to either suspend or postpone any behaviors or engagements which might be interpreted as exclusive, romantic, or sexual in nature by other members of the group or by the trip leaders and chaperones..
- 8) The possession, distribution, or use (in any amount) of alcohol, nicotine, controlled substances, or non-prescribed medication (including any drug paraphernalia) is NOT permitted at any time. Students violating this expectation risk being sent home at the family's expense in addition to disciplinary consequences at school. Parents/legal guardians of students needing doctor-prescribed medications should be in communication with the school and the trip leaders prior to the trip departure date. Please see associated medical forms for further information.

Print Full Name of Student _____

Student Signature _____ **Date** _____

Print Full Name of Parent/Guardian #1 _____

Parent/Guardian Signature _____ **Date** _____

Print Full Name of Parent/Guardian #2 _____

Parent/Guardian Signature _____ **Date** _____

Georgetown University Hospital

CONSENT FOR TREATMENT, RELEASES, ACKNOWLEDGEMENTS AND FINANCIAL AGREEMENT FORM

Students, you must bring to Washington:

1. This form (Consent for Treatment) - Completed & Signed
2. Medical Questionnaire Form - Completed & Signed
3. Insurance Card (or copy of front and back)

By my signature on this form, I agree that I:

1. General Consent for Treatment. Voluntarily consent to and authorize such care and treatments, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications ("Treatments"), by employees and authorized agents of Georgetown University Hospital ("Hospital") as may be considered necessary or advisable in their professional judgment, and may include the drawing and testing for HIV (the virus that causes AIDS) and other blood borne diseases. I further acknowledge that no guarantees have been made regarding the effect such Treatments on any medical condition.

2. Right to Refuse Treatments. Understand that I have the right to make informed decisions regarding all care and Treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any Treatments that I do not want.

3. Assignment of Benefits / Financial Responsibility. Authorize and Assign all claims for and payments of any insurance benefits, workers' compensation benefits, government agency and disability benefits, directly to the Hospital for services rendered. I further assign the proceeds of any settlements, judgments or verdicts from third party liability claims for injuries treated by the Hospital to the Hospital in an amount equal to the outstanding balance of all charges due and owing. I agree that any excess payments may be applied by Hospital to satisfy any outstanding accounts resulting from prior admissions or treatments. As the patient, responsible party, or guarantor of payment for patient, I agree to be responsible for all charges not covered by the patient's insurance coverage or other claims. I further agree that in the event payment is not made in full for all Hospital charges, that to the extent permitted by applicable law, I shall pay all Hospital costs of collection including reasonable attorney's fees and/or collection agency fees.

4. Property Release. Release the Hospital from any responsibility for valuables, money, personal or other possessions which are not properly deposited by me with the Hospital depository and that in any event the Hospital's maximum liability shall be \$500.00.

5. Acknowledgment of Receipt of Notice of Privacy Practices. Acknowledge that I have received or decline the MedStar Health Notice of Privacy Practices and acknowledge that this notice is available for me to keep.

For Georgetown University Hospital Use Only

Patient signature / acknowledgement of receipt of Notice of Privacy Practices not obtained because:

☐ **Emergency patient**

☐ **Patient / Patient Representative declined to acknowledge**

GUH Representative

☐ **Patient / Patient Representative unable / unwilling to acknowledge receipt**

By signing below, I acknowledge that I have read, understand and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Representative to sign this document and be bound by its terms.

Signature of Student

Date

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Relationship to Student

Address

City

State

Zip

Georgetown University Hospital

MEDICAL QUESTIONNAIRE FORM

Students, you must bring to Washington:

1. This form (Medical Questionnaire) - Completed & Signed
2. Consent for Treatment Form - Completed & Signed
3. Insurance Card (or copy of front and back)

Last Name _____ First Name _____ DOB _____

Height ft _____ in. _____ Weight _____ lbs. Date of last tetanus booster _____

Yes No

- ☐ ☐ Do you have difficulty with mobility and/or require assistance to walk such as a wheelchair, crutches, or cane? Describe _____
- ☐ ☐ Do you take any prescription or nonprescription medications regularly? Specify _____
Do you have or have you had in the past any of the following?
- ☐ ☐ A. Any orthopedic problems (acute or chronic sprains, casts)? Date Describe _____
- ☐ ☐ B. Cerebral palsy or other physically debilitating ailment such as MS, JRS, SLE, MD? Describe _____
- ☐ ☐ C. Any allergies severe enough to cause a reaction, such as hay fever or allergies to cigarette smoke, food, bee stings, or other insect bites? Any known drug allergies? Date of Reaction, Describe _____
- ☐ ☐ D. Professional help, evaluation, testing, or hospitalization for a physical or mental condition? Describe _____
- ☐ ☐ E. Any history of seizures, epilepsy, or convulsive disorder (controlled or not)? Describe _____
- ☐ ☐ F. Any gastrointestinal disorders such as nervous stomach, ulcer, or colitis? Describe _____
- ☐ ☐ G. Impaired hearing or deafness, significant loss of sight, or legal blindness? Describe _____
- ☐ ☐ H. Recent operations or significant operations in the past? Describe _____
- ☐ ☐ I. Asthma or any other problem of the respiratory or cardiac system? Describe _____
- ☐ ☐ J. Diabetes? Date Specify insulin type, dose, frequency, and testing method. Describe _____
- ☐ ☐ K. Are you pregnant? Due Date _____
- ☐ ☐ L. Any other chronic conditions ? Please be specific _____

I hereby certify that to the best of my knowledge the above information is complete and accurate.

Signature of Student

Date

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Relationship to Student