



— MERCED COUNTY —
**Office of
Education**



Steve M. Tietjen, Ed.D. | County Superintendent of Schools

632 WEST 13TH STREET | MERCED, CA 95341 | (209) 381-6600 | WWW.MCOE.ORG

6th Grade Camp

STUDENT FORMS

Complete and return ALL forms to YOUR teacher
by: _____

Student Name: _____

Teacher Name: _____

School Name: _____

P.O. Box 69 • Fish Camp, CA 93623 • (559) 642-0122 • Fax (559) 683-2969

NURTURE • SERVE • LEAD

Equal Employment Opportunity



FIELD TRIP PERMISSION SLIP/WAIVER NOTICE/ MEDICAL EMERGENCY AUTHORIZATION

FORM PS-100A



Student Name

School Name

School District

Teacher's Name

I authorize my son/daughter, _____, to participate in the District sponsored activity of *Outdoor Science School Trip to Camp Green Meadows Outdoor School, Fish Camp, CA..* *Students will be exposed to the inherent risks associated with the National Forest, nature and outdoor recreation activities which include hiking, archery, and a climbing wall.*

I understand and acknowledge that these activities, by their very nature, pose the potential risk of serious injury/illness to individuals who participate in such activities.

I understand and acknowledge that while at Camp Green Meadows Outdoor School students may take off campus field trips and excursions and I and my son/daughter agree to assume liability and responsibility for any and all potential risks that may be associated with participation in such field trips and activities, including transportation to and from field trip locations.

The following is common language to all MCOE field trips and volunteer forms: I understand and acknowledge that some of the injuries/illnesses that may result from participating in these activities include, but are not limited to, the following: fractured bones, sprains/strains, unconsciousness, head and/or back injuries, paralysis, loss of eyesight, communicable diseases, and possibly death

I understand and acknowledge that participation in these activities is completely voluntary and as such is not required by the District for course credit or for completion of graduation requirements.

I understand and acknowledge that in order to participate in these activities, I and my son/daughter agree to assume liability and responsibility for any and all potential risks that may be associated with participation in such activities.

I understand, acknowledge, and agree that the District, its employees, officers, agents, or volunteers shall not be liable and I hereby waive, release, and discharge them from any future claims, demands, obligations, or causes of action for any injury/illness or property damage suffered by my son/daughter arising as a result of engaging or receiving instruction in said activity or any activity that is incidental thereto.

MEDICAL AUTHORIZATION

In addition to the previous "Treatment Authorization", in the event of a medical emergency and if I/we cannot be reached, I authorize the School District and its employees to consent to any medical treatment, examination, or tests necessary for the care of this my child. The following are additional emergency contact individuals:

Contact Persons	Relationship	Day time Phone No.	Night time Phone No.
1. _____	_____	_____	_____
2. _____	_____	_____	_____

I further understand that my child may be filmed or photographed during their trip for media coverage or promotional purposes and give permission for such non-commercial use.

I also understand that the Camp Green Meadows Outdoor School and staff are not responsible for lost, damaged, or stolen goods.

I acknowledge that I have carefully read this VOLUNTARY ACTIVITIES PARTICIPATION FORM and that I understand and agree to its terms.

Print Parent/Guardian Name

Signature

Date

A signed VOLUNTARY ACTIVITIES PARTICIPATION FORM must be on file with the District before a student will be allowed to participate in the above extra-curricular activities.

Revised 11/18/21

Emergency Pick Up Form

I, or my emergency designee, will be available 24 hours a day during my child's stay at GMOS. I will be responsive to phone calls from my school, my child's teacher, or GMOS (area code 559). In the event my child needs to be picked up due to COVID-19 symptoms/exposure, other illness, injury, or misbehavior, I will pick up my child within 4 hours of emergency notification. If needed, I will arrange alternate pickup arrangements using the emergency contacts listed below. I have checked that these numbers are current & informed my emergency contacts of this need.

Parent's Name Printed: _____

Parent's Signature: _____

Child's Name: _____

Child's School: _____

Child's Teacher: _____

1st Parent/Guardian: (name) _____ (relationship) _____

Phone Numbers: (cell) _____ (home) _____ (work) _____

2nd Parent/Guardian: (name) _____ (relationship) _____

Phone Numbers: (cell) _____ (home) _____ (work) _____

1st Emergency Contact: (name) _____ (relationship) _____

Phone Numbers: (cell) _____ (home) _____ (work) _____

2nd Emergency Contact: (name) _____ (relationship) _____

Phone Numbers: (cell) _____ (home) _____ (work) _____

Camp Green Meadows Outdoor School

Health Information and Treatment Authorization (page 1 of 2)



FORM MUST BE COMPLETED AND SIGNED IN INK BY PARENT OR GUARDIAN

Name of Student: _____ Date of Birth: _____

School: _____

To help us insure that your child has a pleasant and safe experience, please answer every question and explain any "Yes" answers.

1. Does your child have any health problems which might affect his/her care, such as asthma, diabetes, convulsive seizures, hearing or vision losses, etc.? If YES, please specify. If your child uses an inhaler for asthma, you will need to have the form "Request for Self-Administration of Medication" completed and signed by your child's Health Care Provider. ☐ Yes ☐ No

2. Is your child allergic to or reacted unusually to any medicine, insect sting, food, or other substance? If YES, please give complete details and recommendations (attach additional sheet if necessary). If your child uses an epi-pen or inhaler, you will need to have the form "Request for Self-Administration of Medication" completed by your child's Health Care Provider. ☐ Yes ☐ No

3. Does your child require a special diet? If YES, please explain. If a special diet is required, you will need to contact the Outdoor School Food Service Manager at (559) 642-0122 to make arrangements prior to your child's arrival at the facility. ☐ Yes ☐ No

4. Is there any reason why your child's physical activity should be limited in any way? If YES, please explain fully on a separate sheet and attach to this form a release and recommendations from your Health Care Provider. ☐ Yes ☐ No

5. Is your child covered by health insurance? If YES, please list provider and policy number. ☐ Yes ☐ No

Provider: _____ Policy Number: _____

Insurance Provider Phone # _____ Prescription #: _____

6. Is your child required to take medications? If YES, you MUST have the form "Request for Administration of Medication" completed and signed by your child's Health Care Provider. ☐ Yes ☐ No

If your child requires an injectable drug, the child must have the ability to self-administer. Our staff cannot administer injectable drugs except in an emergency (glucagon, epi-pens). Please be certain to complete BOTH PAGES of the "Self-Administration of Medication" form included in this packet.

For your child's safety- If your child takes medicine, they will not be able to attend the outdoor school unless your Health Care Provider correctly completes the "Request for Administration of Medication" forms indicated in #1, 2 and 6 above and you provide the medications you have listed. All medication must be delivered to your child's school in a store or pharmacy-labeled container with the child's name, name of medication and instructions for administration on the label.

Camp Green Meadows Outdoor School

Health Information and Treatment Authorization (page 2 of 2)



FORM MUST BE COMPLETED AND SIGNED IN INK BY PARENT OR GUARDIAN

Name of Student: _____

School: _____

To help us insure that your child has a pleasant and safe experience, please answer every question and explain any "Yes" answers.

7. Has your student had a tetanus shot? If "Yes", date of most recent inoculation: _____ ☐ Yes ☐ No

8. Has your child recently been exposed to any contagious disease or illness? If "Yes" please give dates of exposure and provide more information. Students with fever or other signs of illness need to remain at home. ☐ Yes ☐ No

9. Is your child subject to carsickness? If "Yes" please consult with your doctor as to whether medications may be helpful. (Remember to fill in the Medication Authorization form and obtain your doctor's signature if sending motion sickness medications) ☐ Yes ☐ No

10. Does your child wet the bed? If "Yes" please provide "Overnight" underwear at least 1 pair per night. These should be provided in a plain package with the medications to the health care staff so that your child's privacy will be respected. ☐ Yes ☐ No

11. Would you like your child's Cabin Leader to make certain they sleep on a bottom bunk? ☐ Yes ☐ No

12. Does your child sleepwalk? If "Yes", How frequently? ☐ Yes ☐ No

13. Is this your child's first time away from home? ☐ Yes ☐ No

Please attach any additional information that you feel will help us support your child's success.

Name of Parents/Guardians: _____

Home Phone _____ Cell _____ Work _____

Name of Family Doctor: _____

Doctor's Phone Number: _____

Authorization for Medical Treatment: Your signature is required in order for your child to receive any necessary medical, surgical and/or hospital care while at the outdoor school or in transit.

I authorize for my child _____ (name) to receive any necessary medical, surgical, and/or hospital care while they are attending and/or traveling to or from the Camp Green Meadows Outdoor School.

DATE: _____ Parent/Guardian Signature (In ink, please) _____

Camp Green Meadows Outdoor School Consent for Self-Administration of Medication



TO BE COMPLETED BY PARENT

(Self-Administration form page 1 of 2, copy as needed for additional medications)

STUDENT GUIDELINES FOR SELF-ADMINISTRATION OF MEDICATION This form is only for Inhalers, Epi-Pens and Insulin. Student possession and self-administration of medication at school or during school-sponsored activities must be performed under the the following conditions:

1. Student medication must be clearly labeled and a back-up kept in the school office.
2. Student has been instructed by a physician on how to take his/her medication and is responsible for self-administration.
3. Student must demonstrate to the school nurse that he/she uses the medication properly and responsibly.
4. Student use of medication will be periodically monitored by the school nurse to ensure that appropriate practices are being followed.

CONSENT FOR SELF-ADMINISTRATION OF MEDICATION

Name of Student: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

For the duration of the outdoor school trip, I hereby consent to allow:
(student name) _____ to self-administer the following
medication during the regular school day or while at school-related activities:

- ☐ Auto-injectable epinephrine
- ☐ Inhaled asthma medication
- ☐ Glucagon
- ☐ Insulin

A written statement from the student's physician will need to be completed, see physician form on page 2.

I further consent to the disclosure of my individually identifiable health information by Physician to the school nurse or other personnel designated by the Merced County Office of Education ("MCOE") for the purpose of consulting with Physician regarding any questions that may arise with regard to the medication.

I acknowledge that I have an obligation to execute a new consent form and notify (email/fax) the Outdoor School immediately if the student's medication, dosage, frequency of administration changes during the period of the trip.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to hold harmless, release, and covenant not to sue the District, its officer, employees, and agents, for any and all liability, claim, or cause of any action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication.

Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Name (print): _____ Phone Number: _____

**Camp Green Meadows Outdoor School Consent
for Self-Administration of Medication**

TO BE COMPLETED BY PHYSICIAN

(Self-Administration form page 2 of 2, copy as needed for additional medications)

Physician's Statement Supporting Student's Self-Administration of Medication

1. Pursuant to Education Code Sections 49423 and/or 49423.1, this is to confirm that:

_____ (student name) DOB: _____ Is able to
self-administer the following medications:

- ☐ Auto-injectable epinephrine
- ☐ Inhaled Asthma Medication
- ☐ Glucagon
- ☐ Insulin

2. The name of the medication is: _____
3. The condition for which the medication is to be administered is: _____

4. The method of self-administration is: _____
5. The amount of medication to be taken per administration is: _____
6. The time schedule of administration of medication is: _____
7. Other Instructions: _____

I certify that the foregoing is true and correct.

Signature of Physician

Date

Printed Name of Physician

Phone Number

Address

Fax Number

Camp Green Meadows Outdoor School

Medication Authorization (page 1 of 2)



Student Name: _____ Birthdate: _____

School: _____ Grade: _____ Teacher: _____

Prescription and nonprescription drugs require parent and physician signatures on each side of this form, as well as on any added copies. Please make copies if more medicines are required.

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Medication 1	Medication 2
Medication Name: _____	Medication Name: _____
Strength (mg, ml, mcg): _____	Strength (mg, ml, mcg): _____
Dose (#of tabs, puffs, etc.): _____	Dose (#of tabs, puffs, etc.): _____
Diagnosis: _____	Diagnosis: _____
Method of Administration: _____	Method of Administration: _____
Time of Administration (circle if appropriate): 8:45am 1:00pm 6:30pm 9:30pm Other: _____	Time of Administration (circle if appropriate): 8:45am 1:00pm 6:30pm 9:30pm Other: _____
Start: ☐ Immediate ☐ Other Date: _____	Start: ☐ Immediate ☐ Other Date: _____
Stop: ☐ Immediate ☐ Other Date: _____	Stop: ☐ Immediate ☐ Other Date: _____
PRN (prescribe as needed): Symptoms: _____ Frequency: _____ Initiate medical referral: _____ ☐ For episodic/emergency events only Reason for Medication: _____	PRN (prescribe as needed): Symptoms: _____ Frequency: _____ Initiate medical referral: _____ ☐ For episodic/emergency events only Reason for Medication: _____
Restrictions and/or important side effects: ☐ None anticipated ☐ Yes (please describe): _____	Restrictions and/or important side effects: ☐ None anticipated ☐ Yes (please describe): _____
Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____	Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____
Comments: _____	Comments: _____

Health Care Provider Signature: _____ Date: _____

Health Care Provider Name (PRINT): _____ Phone: _____

Health Care Provider Address: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

PARENTAL CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Parent(s)/guardian(s) of _____ request that the medicine(s) above be administered by school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. Medication must be furnished by the parent or guardian in its original pharmacy or store-labeled container.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (PRINT): _____ Phone: _____

Address: _____

Camp Green Meadows Outdoor School

Medication Authorization (page 2 of 2)



Student Name: _____ School: _____

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Medication 3	Medication 4
Medication Name: _____	Medication Name: _____
Strength (mg, ml, mcg): _____	Strength (mg, ml, mcg): _____
Dose (#of tabs, puffs, etc.): _____	Dose (#of tabs, puffs, etc.): _____
Diagnosis: _____	Diagnosis: _____
Method of Administration: _____	Method of Administration: _____
Time of Administration (circle if appropriate): 8:45am 1:00pm 6:30pm 9:30pm Other: _____	Time of Administration (circle if appropriate): 8:45am 1:00pm 6:30pm 9:30pm Other: _____
Start: ☐ Immediate ☐ Other Date: _____	Start: ☐ Immediate ☐ Other Date: _____
Stop: ☐ Immediate ☐ Other Date: _____	Stop: ☐ Immediate ☐ Other Date: _____
PRN (prescribe as needed): Symptoms: _____ Frequency: _____ Initiate medical referral: _____ ☐ For episodic/emergency events only Reason for Medication: _____	PRN (prescribe as needed): Symptoms: _____ Frequency: _____ Initiate medical referral: _____ ☐ For episodic/emergency events only Reason for Medication: _____
Restrictions and/or important side effects: ☐ None anticipated ☐ Yes (please describe): _____	Restrictions and/or important side effects: ☐ None anticipated ☐ Yes (please describe): _____
Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____	Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____
Comments: _____	Comments: _____

Health Care Provider Signature: _____ Date: _____

Health Care Provider Name (PRINT): _____ Phone: _____

Health Care Provider Address: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

PARENTAL CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Parent(s)/guardian(s) of _____ request that the above listed medicine be administered by school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. Medication must be furnished by the parent or guardian in its original pharmacy or store-labeled container.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (PRINT): _____ Phone: _____

Address: _____

Medical Statement to Request Special Meals and/or Accommodations

1. School	2. Site Name	3. Site Phone Number
4. Name of Child		5. Age or Date of Birth
6. Name of Parent/Guardian		7. Phone Number
8. Description of Child's Physical or Mental Impairment Affected:		
9. Explanation of Diet Prescription and/or Accommodation:		
10. Indicate Food Texture for Above Child: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed		
11. Adaptive Equipment to be Used:		
12. Foods to be Omitted and Appropriate Substitutions:		
Foods to Be Omitted		Suggested Substitutions
13. Signature of State Licensed Healthcare Professional*		
14. Printed Name	15. Phone Number	16. Date

*For this purpose, the CDE only permits the following state licensed healthcare professionals: licensed physicians, physician assistants, or nurse practitioners.

*This form is also considered valid with a certified digital signature.

The information on this form is required to reflect the current medical and/or nutritional needs of the child.

Instructions

1. **School:** Print the name of the school that is providing the form to the parent/guardian.
2. **Site:** Print the name of the site where meals will be served.
3. **Site Phone Number:** Print the phone number of site where meal will be served.
4. **Name of Child:** Print the name of the child to whom the information pertains.
5. **Age of Child:** Print the age of the child. For infants, please use date of birth.
6. **Name of Parent/Guardian:** Print the name of the person requesting the child's medical statement.
7. **Phone Number:** Print the phone number of parent/guardian.
8. **Description of Child's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child's diet.
9. **Explanation of Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by the state licensed healthcare professional.
10. **Indicate Texture:** If the child does not need any modification, check "Regular".
11. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child with dining (e.g., sippy cup, large handled spoon, wheelchair accessible furniture, etc.).
12. **Foods to be Omitted:** List specific foods that must be omitted.
Suggested Substitutions: List specific foods to include in the diet.
13. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.
14. **Printed Name:** Print name of state licensed healthcare professional.
15. **Phone Number:** Phone number of state licensed healthcare professional.
16. **Date:** Date state licensed healthcare professional signed the form.

Definitions

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

Physical or mental impairment means, any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine; or any mental or psychological disorder such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disability.

Physical or mental impairment includes, but is not limited to, contagious and noncontagious diseases and conditions such as the following: orthopedic, visual, speech, and hearing impairments, and cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional illness, dyslexia and other specific learning disabilities, Attention Deficit Hyperactivity Disorder, Human Immunodeficiency Virus infection (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, writing, communicating, interacting with others, and working; and the operation of a major bodily function.

Major bodily function includes, the operation and functions of the immune system, special sense organs and skin, normal cell growth, and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive systems. The operation of a major bodily function includes the operation of an individual organ within a body system.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form (PDF), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
2. fax: 833-256-1665 or 202-690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.