

SANTA MONICA MALIBU UNIFIED SCHOOL DISTRICT

**(MINOR) STUDENT PARTICIPATION IN VOLUNTARY FIELD TRIP, PARENTAL PERMISSION, ASSUMPTION OF RISK, AND
MEDICAL TREATMENT AUTHORIZATION -- DISTRICT SPONSORED ACTIVITY**

Type of Field Trip (select):

☐ Special Field Trip ☐ Overnight Field Trip ☐ Out of State and/or Foreign Travel Field Trip

Student's Name: _____ Date _____
has my permission to participate in the following field trip: **Program Description and Itinerary are attached along with an acknowledgment form regarding the nature of this trip, levels of supervision, and information pertaining to vendor selection. Please read this information carefully before signing the activity acknowledgment form and waiver of liability attached to this form.**

Destination/Nature of Activity: _____
(Please be specific.)

Dates: **Itinerary Attached; please read carefully and note all travel arrangements.**

Person in Charge: **Please read information pertaining to supervision levels, positions of supervisors, etc., carefully before signing the activity acknowledgment form and waiver of liability.**

Type of Transportation: Various modes of transportation may be used, some of which involve a risk that cannot be ascertained by Santa Monica Malibu School District.

Health or special needs: Check as appropriate.

☐	My student has no special health needs that the staff should be aware of and no prescription medication is required on the trip.
☐	My student has a special health need and/or medications. Instructions and/or Medication at School Authorization form(s) are attached. Number of attached pages:_____.
☐	Other:

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and transportation considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services. I further acknowledge that the District does not provide medical coverage for participants in this activity.

I fully understand that participants are to abide by all rules and regulations governing conduct during the trip.

As provided for in California Education Code Section 35330, I agree to waive all claims against the Santa Monica Malibu School District (District) and hold the District, its officers, agents and employees, harmless from any and all liability or claims, which may arise out of or in connection with my child's participation in this activity. This waiver shall not apply to any occurrences which may arise solely out of the negligence of the District, its employees or agents.

Parent's Signature Please Print Date

Work Phone () _____ Home Phone () _____

Student's Signature Please Print Date

Family Medical Insurance Carrier: _____ Policy Number: _____
(Example, Blue Cross)

In the event of an emergency, please contact:

Name Relationship
Work Phone () _____ Home Phone () _____

SANTA MONICA – MALIBU UNIFIED SCHOOL DISTRICT
Department of Health Services

Medication at School Form

This form must be renewed at the beginning of each school year and whenever there is a change in the medication order.

Student Name: _____ Date of Birth: _____
Last First MI

School: _____ Student ID #: _____ Grade: _____

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER

Diagnosis or Reason for Medication during the school day: motion sickness/nausea, itching/skin discomfort

Name of Medication	Method of Administration	Dose	Time(s) to be given	Frequency & Symptoms for "as needed"
☐ _____	by mouth	☐ tab(s) every ☐ hours		as needed for motion sickness/nausea
☐ Hydrocortisone 1%	topical to affected area(s)	apply small amount as needed, up to two(2) times daily		for itching/discomfort
☐ Calamine/Zinc oxide	topical to affected area(s)	apply small amount as needed for mild itching/discomfort, avoid eyes		

Precautions, reactions, or side effects: see manufacturer packaging/label/insert

Medication to be administered by: ☒ Designated Unlicensed School Personnel (indirect supervision by a licensed nurse)

In my professional opinion this student: May ☐ May Not ☒ carry (ONLY) asthma inhalers, auto-injectable epinephrine or insulin/diabetes medications.

Health Care Provider Full Name (PRINTED or STAMPED)	Address	Telephone Number
Authorized Health Care Provider SIGNATURE	NPI#	Date

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I request that the school staff assist my child with medication as ordered by the health care provider. I give permission for the school nurse to communicate with the health care provider on matters related to these medications.

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, health care provider's name, medication, dose, method of administration, and time to administer (over-the-counter medications must be in the original containers). The medication must be delivered to the school by the parent, guardian or adult designee.

I understand that my child may only take the medications at school (including over-the-counter) if the school has received ALL of the following: 1) Current California authorized health care provider order, 2) Parent/guardian signature, and 3) Properly labeled medications.

I authorize a designated member of the school staff to assist my student with medication as ordered by the health care provider. In the case of a field trip, I authorize parent volunteers/camp staff to assist my child with medication, as above.

Parent/Guardian Name (PRINT)	Parent/Guardian Signature	Date	Telephone
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SANTA MONICA – MALIBU UNIFIED SCHOOL DISTRICT
Department of Health Services

Medication at School Authorization Form

This form must be renewed at the beginning of each school year and whenever there is a change in the medication order.

Student Name: _____ Date of Birth: _____
Last First Middle

School: _____ Student ID# _____ Grade _____

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER

Diagnosis or Reason for Medication during the school day: _____

<i>Name of Medication</i>	<i>Method/Route of Administration</i>	<i>Dose</i>	<i>Time(s) to be given</i>	<i>Frequency & Symptoms for "as needed"</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Precautions, reactions, or side effects: _____

Medication to be administered by: ☐ Designated Unlicensed School Personnel (indirect supervision by a licensed nurse)

In my professional opinion this student: May ☐ May Not ☐ carry (ONLY) asthma inhalers, auto-injectable epinephrine or insulin/diabetes medications.

Health Care Provide Full Name (PRINTED or STAMPED, Address, Telephone) _____

Authorized Health Care Provider SIGNATURE

NPI#

Date

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I request that the school staff assist my child with medication as ordered by the health care provider. I give permission for the school nurse to communicate with the health care provider on matters related to these medications.

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, health care provider's name, medication name, dose, method of administration, and time to administer (over-the-counter medications must be in the original containers). The medication must be delivered to the school by the parent, guardian or adult designee.

I understand that my child may only take the medications at school (including over-the-counter) if the school has received ALL of the following: 1) Current California authorized health care provider order, 2) Parent/guardian signature, and 3) Properly labeled medications.

I authorize a designated member of the school staff to assist my student with medication as ordered by the health care provider. In the case of a field trip, I authorize parent volunteers/camp staff to assist my child with medication, as above.

Parent/Guardian Name (PRINT)

Parent/Guardian Signature

Date

Telephone

Santa Monica-Malibu Unified School District
1717 Fourth Street, Santa Monica, California, 90401 (310) 450-8338
Department of Health Services

MEDICATION DURING SCHOOL HOURS

Every effort should be made to have any student medications **given at home if possible**. Should your student's doctor prescribe a medication, request that they give you a schedule so that it can be administered at home.

ALL medications, *including non-prescription medications* require **written authorization from a doctor AND parent/guardian**.

If your child does need to take medication every day at school or during an illness, here are the rules to follow:

1. Medication(s) **must be brought to school by the parent/guardian or adult designee** and given to the nurse or other health office personnel. Medication(s) are kept locked in the Health Office at school.
2. Medication(s) must be **kept in the original prescription, pharmacy-labeled bottle**.
3. Medication must be **accompanied by a physician's written order with the following information**:
 - o Student's name
 - o Diagnosis (need for medication)
 - o Medication name, dosage, time to be given at school
 - o Length of treatment (i.e. school year 2024-2025)
 - o Physician's full name, address and phone number along with their SIGNATURE
4. The medication must be accompanied by the parent or guardian's written permission for administration of medication at school.
5. If the medication is to be taken all school year, please check the expiration date of the medication before it is dropped off to be sure it will last until the last week in June of the school year.
6. The completed **Medication at School Authorization form AND the medication(s) should be brought to the school nurse at the beginning of the school year** or when your child needs the medication for an episodic illness.
7. It is recommended that parents/guardians for students taking daily medication, (either at home or at school), provide the school with a 3-day supply of their medication in case of a disaster.

Medication Distribution Guidelines

ABSOLUTELY NO MEDICATIONS MAY BE DISTRIBUTED WITHOUT COMPLETING THE FOLLOWING STEPS:

1. COMPLETED PHYSICIAN'S ORDER (MEDICATION AT SCHOOL AUTHORIZATION) FORM
2. PHYSICIAN'S SIGNATURE
3. PARENT/GUARDIAN SIGNATURE
4. MEDICATION CONTAINER LABELED WITH:
 - student's full name
 - name of medication
 - medication dosage
 - dosage time
 - expiration date.

These guidelines are in effect for **both prescription and/or over the counter medications**. Any student needing medication during school hours **MUST** keep medication(s) in the health office **ONLY**. **Absolutely NO medication should be kept in student's backpack, pocket, lunch box, etc. except for asthma inhalers, auto-injectable epinephrine or insulin/diabetes medications as authorized by your child's health care provider**. Please request that your health care provider be as specific and concise when providing instructions for the school to follow. These guidelines have been established to ensure the safety of your child as well as other students who may visit the health office at your school. Your cooperation is greatly appreciated.