

## FWHS Music Dept. Orlando Field Trip

Trip Dates: March 25-29, 2015

Forms in this packet due: Thurs. Jan. 22nd

Dear Music parents and students,

At this stage in the planning process, we need information from you for the flight manifests and for the school nurses. Please read and complete each page of this packet carefully.

For your planning, please know 1 more packet will be distributed as the trip date gets closer. It will contain the finalized itinerary, items to bring with you on the trip, instructions for packing & luggage requirements, behavioral expectations & policies, contact information, and a signature page (which you will return).

Students have received instructions about choosing roommates and should keep an eye on the blue bulletin board for a finalized list of students going on the trip as well as Mr. Marsland's schedule. Please be sure to approach Mr. Marsland with ALL of your roommates present (during a time he has available) in order to sign up for your room.

Each director will communicate their own Orlando music rehearsal plans/expectations. ALL students, their parent/guardian, and chaperones will be required to attend the Trip Kickoff meeting on **Tues. March 24<sup>th</sup>, 7:30pm** in the auditorium.

### Instructions for this packet

Please return the following documents stapled together to your director by Jan. 22<sup>nd</sup>.

1. Flight Manifest Document
2. A photocopy of your ID (see instructions on Flight Manifest sheet)
3. Medical Release Form

\*Do not return the Authorization of Parent or Guardian for Administration of Medication in School form with the others. (See below)

If a student plans to bring medicine on the trip (or have medicine distributed to them), all medicines need to be documented. You will need one *Authorization of Parent or Guardian for Administration of Medication in School* form for each medication brought on the trip. (You might need to make copies of this form). You should deal directly with the FWHS nurse's office for this. Please bring the form(s) and medicine(s) to them no later than Feb. 27<sup>th</sup>. \*\*No medicine of any kind (even over the counter medicine and vitamins) can be distributed without an authorization form on record. Each form needs a physician's signature.

Thank you!

Mrs. Verney-Fink, Mr. Marsland, and Mr. Zheleznyak

## Orlando Trip Flight Manifest Information

Please provide the following information for the flight manifest document AND turn in a photocopy of your ID on the backside (top corner) of this paper. See next paragraph for more info.

All students who will be 18 or older when they board the flights will need to show a government issued ID. All information provided below must EXACTLY match your ID. For students under 18, please plan to provide your school ID. Be sure your information EXACTLY matches your student ID.

PLEASE COMPLETE IN ALL CAPITAL LETTERS

FIRST NAME: \_\_\_\_\_

MIDDLE NAME (IF APPLICABLE): \_\_\_\_\_

LAST NAME: \_\_\_\_\_

BIRTH MONTH: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

BIRTH YEAR: \_\_\_\_\_

GENDER (male or female): \_\_\_\_\_

Student signature: \_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

**MEDICAL RELEASE FORM**  
**Fairfield Warde High School Orlando Trip (March 2015)**

I hereby give permission for my child, \_\_\_\_\_  
to receive any medical treatment deemed necessary in the case of an emergency. I will assume all  
responsibilities for any medical services rendered. I understand that every effort will be made to contact me  
beforehand. I have listed any known medical conditions in the space provided below.

Known medical problems:

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Reactions (allergies) to medications:

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*Severe food allergies/restrictions. Note: All meals except for breakfasts at the hotel will be "on their own." (Ex: students will receive a coupon for a dinner that can be used at several locations in the Disney Parks). Students should communicate their dietary restrictions to any food vendor/restaurant where they purchase food. The hotel's breakfast will consist of...scrambled eggs, 1 meat (rotation of ham, bacon, or sausage), 1 starch (rotation of pancakes, French toast, or breakfast potatoes), whole fruit (banana or apple), dry cereal with milk (we have requested that a dairy free option be provided), pastries, muffins, coffee, juice, and tea.*

Parent/Legal Guardian Name (s) For Emergency Contact:

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Address:

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Home Phone Number: \_\_\_\_\_

Cell Phone Contact: \_\_\_\_\_

Daytime/Business Phone Number: \_\_\_\_\_

If needed:

Secondary Emergency Contact (Not Parent) \_\_\_\_\_  
(Name) (Phone)

Parent/ Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Fairfield Warde High School**  
755 Melville Avenue Fairfield, CT 06825  
203 255-8354 Fax 203 255-8212

James J. Coyne  
Headmaster  
Caryn F. Campbell  
Director, Student Services  
David M. Ebling  
Fitts Housemaster  
Steven L. Fekete  
Townsend Housemaster  
Deirdra A. Preis  
Pequot Housemaster  
Seth C. Fry  
Athletic Director

RE: Trip to Orlando  
March 25 -29, 2015

Dear Parents:

Students participating in overnight school sponsored trips are required by state law to have a medical authorization form filled out by the physician **and** parent for any medications brought on the trip. **This is required for both prescription and over the counter medications.** A medication authorization form is attached. Additional medication authorization forms are available in the health office. Please note: a new CT State regulation states that the medication form must contain the generic name of the medication. Also, all medications must be in the original container with proper label.

Students who already have a physician's medical authorization on file with the school nurse do not need to have another authorization form completed for that prescription. However, any additional doses of that medication will require a physician's medication authorization to be completed for those doses.

Certain self-administered medications, such as inhalers, Epipens, and some over the counter medications may be carried by the student during the trip. (Medication authorization forms are still required for these medications.) All other medications will be carried by the designated teacher chaperone.

It is important that these forms are returned to the health office by **Friday, February 27, 2015**. Please feel free to call us with any questions at 255-8358.

Yours truly,

Millie Sacks RN  
Meg MuldoonRN

School Nurses

# TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

## AUTHORIZATION OF PARENT OR GUARDIAN FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant, Optometrist or Podiatrist (for interscholastic and intramural events only), licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Medication \_\_\_\_\_

I hereby give my permission for my child to receive the above medication in school as ordered by his/her physician or other authorized prescriber.

Self-administration of medication means that the student will carry and administer his/her medication without assistance.

Student may self-administer the above medication: (circle one): Yes No

For daily medication - Plan for early dismissal days (check one):

- Give medication in school as usual
- Do not give medication in school

Plan for delayed opening:

On days that opening of school is delayed, the parent or guardian must notify the school nurse if any change in the student's medication schedule is needed.

I give my permission for communication between the school nurse and prescriber of this medication as needed for implementation of that medication order in school.

I authorize that this medication be destroyed if it is not picked up within one week following termination of the medication order or by dismissal on the last day of school, whichever comes first.

\_\_\_\_\_  
Date Signature of Parent or Guardian Telephone

\_\_\_\_\_  
Print Name of Parent or Guardian

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### MEDICATION ORDER

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Condition for which Drug is being Administered \_\_\_\_\_

BRAND Name AND GENERIC Name of Drug (PER STATE REGULATION)

Dosage \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time to be given in school: \_\_\_\_\_

Administer Drug: from \_\_\_\_\_ to \_\_\_\_\_  
Date Date

Side Effects/Plan for Management: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Self-administration of medication means that the student will carry and administer his/her medication without assistance.

Student may self-administer the above medication: (circle one): Yes No

\_\_\_\_\_  
Date Signature of Prescriber MD/DO/DDS/APRN/PA/OD/DPM

\_\_\_\_\_  
Print Name of Prescriber

\_\_\_\_\_  
Address and Telephone