Band Camp Forms Checklist

Student Name: _____Date: _____

The following forms are due Tuesday, May 21, 2024:

- ☐ Parent Consent Form (DCS Form 2340 F2)

  Parent/guardian signature required.

- ☐ District Sponsored Overnight Trip Medical Authorization Form (DCS Form 2340C F1)

  Parent/guardian signature required. <u>Must be notarized</u>. Physician signature required for those bringing prescription medications to camp.

- ☐ Responsibility Contract for Overnight Trips (DCS Form 2340C F3).

  Student and parent/guardian signature required. <u>Must be notarized</u>.

- ☐ Photocopy of current Immunization Record
- ☐ Photocopy of both sides of current Health Insurance Card
- ☐ Check for Band Fees made payable to "Dublin Music Boosters" for $605

<u>Optional</u>: The following forms should be included as needed:

- ☐ Asthma Action Plan and Orders (DCS Form 5330A A F1).

  Parent and physician signatures required.

- ☐ Allergy and Anaphylaxis Emergency Orders and Action Plan. (DCS Form 5330A E F1).

  Parent and prescriber signatures required.

Please include any other form found at the Dublin City Schools website that will be needed for the health needs of your child.

<u>Please staple all forms together with this checklist on top.</u>

Dublin City School District

Parent Consent for Trip Form

Program
2340 F2
Revised 4/6/09

- Parent/custodian/guardian is to read and complete this form.
- The form is to be returned to the staff member in charge of the trip.

I, _____ (Parent/Guardian name),

permit my child, _____ to participate in

the trip to all Dublin Jerome Band events for the 2024-2025 school year.

I understand that this trip is part of the District's educational program and provides a learning experience of educational value to my child.

_____ _____

Parent/Guardian signature Date

Dublin City School District

Overnight Trip
Medical Authorization Form

- Upon central office approval of an overnight trip, the teacher in charge should distribute this form to all participating students.
- Parent/guardian is to read and complete this form, **have it notarized**, and return it to the teacher in charge of the trip. **Incomplete or non-returned forms shall result in the student being excluded from participation.**
- The teacher in charge of the trip shall take all completed forms on the trip for medical emergencies.
- All requests for chaperones to administer any medication requires an Ohio health care prescriber's signature.

Student's name: _____ Sex: _____ Birthdate: _____

Home address: _____ City: _____ Zip: _____

Mother/guardian's name: _____

Phone (H): _____ (W): _____ (Cell or Pager): _____

Father/guardian's name: _____

Phone (H): _____ (W): _____ (Cell or Pager): _____

EMERGENCY NUMBERS (if parent/guardian cannot be reached):

1. Name: _____ Phone (H): _____

Relationship to student: _____ Phone (W): _____

2. Name: _____ Phone (H): _____

Relationship to student: _____ Phone (W): _____

Student's health care provider: _____ Phone: _____

Medical insurance company: _____ Group No.: _____

Insurance company address: _____

Name of policy holder: _____ Identification/Policy No.: _____

If you have insurance, please attach a copy of the front and back of your insurance card to this form.

GENERAL HEALTH CARE INFORMATION

Please provide a copy of most current immunization record.

If your child was recently hospitalized, has a fracture or needs specific medical care, please attach written health care provider instructions to this form.

Please check all that apply to your child.

☐ Animal Allergies	☐ Poison Ivy allergy	☐ Activity restrictions	☐ Heart problem
☐ Bee/Insect Allergies	☐ Bleeding problem	☐ Dietary restrictions	☐ Migraines
☐ Drug Allergies	☐ Mobility concerns	☐ Asthma	☐ Glasses/contacts
☐ Environmental Allergies	☐ Sleep walking	☐ Seizures	☐ Ear infections/aids
☐ Food Allergies	☐ Bed wetting	☐ Diabetes	☐ Other _____

Please describe any medical condition including severity and treatment. _____

_____

Food Restrictions/Allergies: _____

Overnight Trip
Medical Authorization Form

Student's name: _____

MEDICATION

- Students in middle and high school may self-carry their nonprescription and/or emergency medication.
- Parent/guardian is responsible for supplying all medication in its original container, labeled with student's name, and should only include the total number of doses needed for the duration of the trip.
- All medication to be administered by a chaperone will require signed approval by a healthcare prescriber.
- For medication administration procedure, see Board Policy 5330, "Use of Medications".
- Please follow the direction of the trip coordinator for medication drop off procedure.
- Section "A" (Chaperone Administered Medication & Emergency Medication) is to be completed and signed by an Ohio licensed healthcare prescriber.
- Section "B" (Self-Carry Medication [Nonprescription Medication]) is to be completed by the parent/guardian.
- Section "C" is the Parent/Guardian Authorization, Emergency Consent, and Signature.

SECTION A – CHAPERONE ADMINISTERED MEDICATION & EMERGENCY MEDICATION (prescriber to complete)

Medication	Dose/Route	Time(s) to be given	Side Effects

Please list any special storage or considerations: _____

If medication is an inhaler, EpiPen, or medication and supplies for diabetic management, may the student self-carry? Yes ____ No ____

As a licensed health care prescriber in the state of Ohio, and at the request of this student's parent/guardian, I direct that the above medication(s) be administered as indicated above.

Prescriber's printed name and title: _____

Prescriber's signature: _____ Phone: _____ Date: _____

SECTION B – SELF-CARRY MEDICATION (Nonprescription Medication) (parent/guardian to complete)

Medication	Dose/Route	Time(s) to be given	Side Effects

SECTION C – PARENT/GUARDIAN AUTHORIZATION, EMERGENCY CONSENT, AND SIGNATURE

PARENT AUTHORIZATION AND EMERGENCY CONSENT

The information on this form is correct and complete to the best of my knowledge, and my child has my permission to participate in this event, with restrictions as noted. I understand and consent to the sharing of this information with all appropriate personnel who will be supervising my child for the duration of this trip or who may be responsible for the welfare of my child.

In the event I or another legal guardian cannot be reached in a medical or dental emergency, I consent for a school staff member to accompany my child to a medical facility. I authorize emergency medical or dental treatment by a licensed physician or dentist.

This authorization does not cover major surgeries or treatments unless the medical opinions of two other licensed physicians or dentists concur in the necessity and urgency for such surgery/treatments BEFORE they are performed.

NOTARY WITNESS TO PARENT/GUARDIAN SIGNATURE

Parent/guardian signature _____ Date _____

State of Ohio, County of _____

The foregoing instrument was acknowledged before me this _____ day of _____

by _____.

_____
Notary Public
My commission expires _____

Dublin City School District

Program
2340C F3
Revised 3/6/2020

Responsibility Contract for Overnight Trips

- Student is to read and complete this form.
- Parent/custodian/guardian is to read and complete this form.
- The completed form is to be notarized and returned to the staff member in charge of the trip (Trip Leader), submitted to the building principal, and left in the file in the building office. Copies are to be given to the Trip Leader and Parent/Guardian.

It is a privilege for you to participate in the District-sponsored trip to _____. Because this trip is part of the District's educational program, it is imperative that you adhere to the Code of Conduct for overnight trips as well as the applicable provisions of the general Code of Conduct/Student Discipline Code. You must remember that from the time of departure to your arrival home, you are the responsibility of the District.

I agree:

1. to refrain at all times from the consumption of alcoholic beverages and/or drugs, except parent or prescriber approved medications.
2. to sleep in my assigned room and not entertain other individuals in my room, unless my room door is fully opened and an adult chaperone is notified and/or present.
3. to keep my assigned chaperone advised of my whereabouts at all times.
4. to attend all mandatory activities and meal functions.
5. to adhere to all established curfews.
6. to conduct myself in such a manner as to bring pride to my family, my school, my community, and myself.
7. to adhere to any established dress code.
8. to comply, throughout the trip, with any and all instructions directed to me and/or the group by a chaperone or staff member.

If a problem arises that is serious enough in nature to warrant the below-named student's removal from the travel group, we (the student and parent/guardian) agree to bear any additional costs to return the student home. NOTE: the accompanying professional staff member will make this removal decision after a student has been provided the opportunity to respond to any allegations. The student may also be subjected to discipline upon his/her return home in accordance with general District policies.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The State of Ohio, County of _____.

The foregoing instrument was acknowledged before me this _____ day of _____

by _____.

_____
Notary Public

My commission expires: _____

Original: Building Copies: Trip Leader, Parent/Guardian

Dublin City School District

Asthma Action Plan and Orders

Student's name: _____ Birthdate: _____ Phone: _____

Student's address: _____ School/Grade: _____
street city state zip

I. Healthcare Provider's Section

Severity classification ☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent
Asthma triggers ☐ none ☐ animals ☐ cold air ☐ exercise ☐ pollen ☐ respiratory illness
☐ smoke, chemicals, strong odors ☐ other (food, emotions, insects, etc.) _____
Peak flow meter personal best _____

Quick relief medication orders: (check the appropriate quick relief med(s)) ☐ Uses inhaler with spacer
☐ Albuterol (strength _____): ____ puffs (Proair®, Ventolin HFA®, Proventil®) as needed every ____ hours for cough/wheeze
☐ Levalbuterol (strength _____): ____ puffs (Xopenex®) as needed every ____ hours for cough/wheeze
☐ Other _____ Epi auto-injector ☐ 0.3 mg ☐ Jr.0.15 mg

SIDE EFFECTS of medication(s): _____

Green Zone: Doing Well
Symptoms: Breathing is good – No cough or wheeze
Peak flow meter _____ (more than 80% of personal best)
Physical activity: ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity
☐ with all activity ☐ when the child fees he/she needs it

Yellow Zone: Caution – DO NOT LEAVE STUDENT UNATTENDED
Symptoms: Problems breathing – Cough, wheeze, or chest tight
Peak flow meter _____ to _____ (between 50% and 79% of personal best)

- If student is using quick relief inhaler > 2 times a week or requires frequent observation by school staff → **Notify** parents + school nurse.
- If student is coughing, wheezing and having difficulty breathing:
  ☐ Give ____ puffs of quick relief inhaler. May repeat in ____ minutes. → **Notify** parents and school nurse if repeated.
- If **NO** improvement after repeated dose, call 911 – see below.

Red Zone: CALL 911 and DO NOT LEAVE STUDENT UNATTENDED
Symptoms: Difficulty talking – Shortness of breath – Getting worse instead of better –
Blue appearance (lips/nails) – Medicine is not helping
Peak flow meter _____ (less than 50% of personal best)
☐ Give ____ puffs quick relief inhaler or nebulizer treatment and **notify** parents and school nurse.
☐ This student needs Epi auto-injector for severe asthma attacks and
☐ can carry and self-administer Epi auto-injector ☐ needs help giving the Epi auto-injector ☐ other _____

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Special storage instructions: _____

Start date: _____ End date: _____

Healthcare provider

Name _____ Date _____ Phone _____ Signature _____

Student's name: _____ Birthdate: _____

II. Parent/Guardian's Section

I hereby request and give my permission for school district personnel to administer this prescribed medication to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of this medication to the school clinic and will notify the school immediately if we change our medical provider or the need for this medication is discontinued.

I understand this medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities

A new Asthma Action Plan and Orders form must be submitted each school year.

I understand that if any changes are needed on this Asthma Action Plan and Orders form, it is the parent's responsibility to contact the school nurse and submit a new form.

I understand that my child may be eligible for Section 504 plan.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Parent/Guardian signature Date

Home address Daytime phone

Dublin City School District

Allergy and Anaphylaxis Emergency Orders and Action Plan

Student's name: _____ Birthdate: _____ Phone: _____

Student's address: _____
street city state zip

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

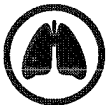
Extremely reactive to the following: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING: **SEVERE** SYMPTOMS



LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - Antihistamine
  - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Adverse reaction to be reported to prescriber: _____

_____

Adverse reactions that may occur to another child for whom the epinephrine is not prescribed, should such a child receive a dose of the medication:

_____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

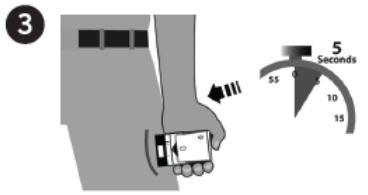
Start Date: _____ End Date: _____

Parent/Guardian authorization signature Date Physician/HCP authorization signature Date

Allergy and Anaphylaxis Emergency Orders and Action Plan (cont.)

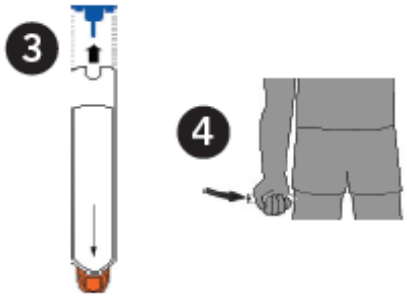
Student's name: _____

AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



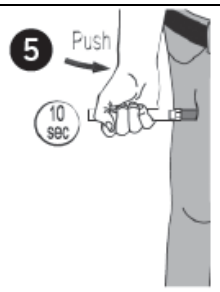
1. Remove Auvi-Q® from the outer case.
2. Pull off the red safety guard.
3. Place black end of Auvi-Q® against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.

EPIPEN®, EPIPEN JR®, AUTHORIZED GENERIC OF EPIPEN®, or USP AUTO-INJECTOR, MYLAN DIRECTIONS



1. Remove the EpiPen®, EpiPen Jr®, authorized generic of EpiPen®, USP auto-injector, Mylan from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES DIRECTIONS



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION

SELF-CARRY AUTHORIZATION

[ ] Physician acknowledgement of training in the proper use of auto-injector
[ ] Self-carry (student is capable of possession and proper use of auto-injector)

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS – CALL 911

Rescue Squad: _____
Doctor: _____ Phone: _____
Parent/Guardian: _____ Phone: _____

OTHER EMERGENCY CONTACTS

Name/Relationship: _____
Phone: _____
Name/Relationship: _____
Phone: _____

Physician signature Date

Parent/Guardian authorization signature Date