

# Chimacum Middle School

## Sixth Grade - Outdoor Education Program

### CISPUS

Dear Parents,

This year's Sixth Grade Outdoor Education Program will be at Cispus in Randle, Washington. This learning experience will be like no other! We will be teaching some of our basic Science, Social Studies and Language curriculum, a sense of community, and the need to cooperate. The adventure and the independence gained will be an unforgettable part of your child's education. We are looking forward to having your child with us on this great adventure. Our Outdoor Education Program has been part of the curriculum for over 20 years and we expect it to be a very rewarding experience.

The trip will take place **Tuesday, September 14 to Friday, September 17**. The students, counselors and staff will be staying in bunkhouses at Cispus. For those of you who like to plan ahead, a suggested packing list is on the back of this letter. Students may bring their gear to school on **Monday, September 13** for check-off so as not to make it a last minute event on Tuesday morning. Monday the 13<sup>th</sup> students will be participating in many Cispus activities here at school to prepare us for the week.

You may need to be available during the week to come pick up your child from Cispus if your child:

1. Doesn't manage own behavior and becomes a safety risk to others.
2. Becomes ill while at camp.

If you need to contact your child at camp, please call the Middle School Office and they will forward all messages to us. Students will not be calling home without staff permission and adult supervision.

The cost to each student for the trip (which covers room and meals) is \$150 (**this price is non-refundable**). You will need to make payments or pay in full at the middle school office if you have not paid already.

Please read, complete and return the attached **Permission Slip and Health Information** form to your student's core teacher by **Thursday, September 9**, so that all of the information can be compiled in time for camp. That's only three days after school starts so please work on this during the summer so you can have all your paperwork ready when school starts.

If you have any questions, please feel free to call any of the sixth grade staff at the Middle School office, 732-4219.

Sincerely,

Laurie Olafson, Joni Langston, Shawn Meacham and Al González

# **CISPUS**

## **RECOMMENDED PACKING LIST**

Camp gear should include:

- Bug repellent
- Sleeping bag OR 1 twin fitted sheet and 2 blankets
- Pillow
- Favorite stuffed animal (small size)
- Pajamas
- Slippers
- Toiletries: toothbrush, toothpaste, kleenex, soap, hairbrush, comb, deodorant, shampoo, personal towel and washcloth. (Showers are available for use.)  
(No glass containers please.)
- Change of clothes for each day - Dress for the weather.
- Extra pair of underwear and socks (in case of rain)
- 2 pairs closed toed shoes for hiking
- Warm coat or jacket
- Extra sweatshirt
- Warm hat for the evenings
- Raincoat or rain poncho  
- We will be doing activities rain or shine.
- Flashlight with new batteries.
- Plastic bag for wet and/or dirty clothes
- Water bottle (clearly marked with student's name on it)
- Book for reading

### Optional

- Disposable camera
- Sunscreen
- Sunglasses

**Bring a dayback or backpack with a lunch, drink, snacks and something to do on the way to Cispus (cards, books – no electronics). You will have this on the bus with you.**

### **PLEASE DO NOT BRING:**

- Electronic games, iPods, cell phones or laser pointers
- Radios or boom boxes
- CD or DVD players
- Incense, candles or anything with an open flame
- Gum, candy, soda pop or other snacks - **NO EXTRA FOOD**  
- Healthy food and snacks will be provided.
- Breakables of any kind
- Pocket knives
- Medications (tylenol, Benadryl, etc.) All medications must have been checked into the office along with the Authorization for Administration of Medication at School form.  
*See Health Form.*

## CHIMACUM SCHOOL DISTRICT Field Trip Permission Form

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

**General Information:** Return this form to your child's school before Friday, 9-10-10 and keep any attachments for your information.

The <u>6th Grade</u>	
is planning a trip to: <u>Camp Cispus</u>	
The purpose of this trip is: <u>Our Outdoor Education Program</u>	
Trip destination: <u>Randle, WA</u>	Phone: _____
Address: _____	
Place of Lodging (if applicable): <u>Bunkhouses at camp.</u>	
We will leave from: <u>School</u>	Date/Time: <u>9-14-10, 8:15am</u>
We will return to: <u>School</u>	Date/Time: <u>9-17-10, 1:45pm</u>

Itinerary Attached  List of Items Attached

Number of Students Attending: <u>80</u>	Number of Adults Attending: <u>7 + 13 HS Counselors</u>
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**Type of Transportation:** District Vehicle  District Bus  Walking  Private Vehicle

Commercial Transportation (describe): \_\_\_\_\_ Other \_\_\_\_\_

*Information below is to be completed by the guardian of the student.*

**Medical Information:** The following special health problems should be noted and adequate precautions taken (list such items as unusually severe reaction to bee stings, other severe allergies, hemophilia, diabetes, heart disease, etc.)

The following medications, prescriptions or special diets are needed:

**Medical Release:** In the event of an accident or illness, I understand that reasonable effort will be made to contact the guardian immediately. However, if I am not available, I authorize the school district to secure emergency medical care, as needed.

Name of Preferred Doctor: _____	Phone: _____
Name of Insurance Carrier: _____	

This activity provides a learning experience for students and allows them an opportunity to apply their classroom learning. Although I understand that the school district will make reasonable efforts to provide a safe environment, I am fully aware of the special dangers and risks inherent in participating in the activity. Being fully aware of the risks, I hereby give consent for my child to participate in the activity.

Guardian Name: (print) _____	Home Phone: _____
Address: _____	Work Phone: _____
Guardian Signature: _____	Emergency Phone: _____

# CHIMACUM OUTDOOR EDUCATION HEALTH FORM

Please complete this entire form.

Student Name \_\_\_\_\_  
Parents/Guardians Name \_\_\_\_\_  
Parents/Guardians Phone Number \_\_\_\_\_ (day) \_\_\_\_\_ (evening)  
Cell Phone \_\_\_\_\_  
Emergency Contact #1 \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency Contact #2 \_\_\_\_\_ Phone \_\_\_\_\_  
Doctor to Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company and Number \_\_\_\_\_

## Health: History & Current

1. Does your child have any allergies? \_\_\_\_\_ If so, to what? \_\_\_\_\_  
Treatments: \_\_\_\_\_
2. Does your child have an allergy to bee stings? \_\_\_\_\_ If so, how severe? \_\_\_\_\_  
Treatments: \_\_\_\_\_  
If **ANY** medication is needed, a doctor's authorization form is required. Bring it to the middle school office by Thursday prior to leaving.
3. Does your child have asthma? \_\_\_\_\_ If any medication is required, a doctor's authorization form is required for it to be brought to school so that we can take it to camp.
4. Are there any other medical considerations that the staff or nurse should be aware of? \_\_\_\_\_ If yes, please describe. \_\_\_\_\_
5. Are there any personal considerations (i.e. bedwetting) that the staff or nurse should know about? \_\_\_\_\_ If yes, please describe. \_\_\_\_\_
6. Does your child need vegetarian meals? YES \_\_\_\_\_ NO \_\_\_\_\_

All information on this form will remain confidential.

All medications (prescription and **over the counter - includes a non-aspirin pain reliever or Benadryl**) needed for students while at camp shall have a Authorization form completed (enclosed) by you and your child's doctor and the medicine, (in its original container), should be checked in at school prior to leaving for the trip, no later than **Thursday, September 9**. All medications will be locked up and distributed by the camp nurse. **EACH MEDICATION MUST HAVE ITS OWN FORM.**

I hereby authorize Chimacum School District personnel to make decisions for \_\_\_\_\_ in the event of a medical emergency, including obtaining medical or hospital care. I understand that there will be a registered nurse accompanying the group and is authorized to give medications as stated above.

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



# AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

## THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

This authorization will expire at the end of the school year, or earlier as determined by the health care provider.

Student \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

Prescribing Health Care Provider's Name/Phone \_\_\_\_\_

### CHECK THE BOX THAT APPLYS TO YOUR CHILD:

- I request that a trained school staff member assist my child to take the medication described below, according to the health care provider's instructions. The medication will be stored for the student in the health room.

*I acknowledge that the School District shall incur no liability as a result of any injury arising from my child's self-administration of his/her medication. I shall indemnify and hold harmless the District and it's employees or agents against any claims arising out of the self-administration of medication by my child.*

- For Inhaler or EpiPen: My child has my permission, and is capable and responsible enough, to carry and self administer an asthma inhaler or EpiPen as authorized below. See #9 on the back.
- My middle or high school age child ONLY has permission to carry and self administer a single dose/day of this medication as approved by the medical provider, principal and school health consultant. See #8 on the back.

\_\_\_\_\_ Date

\_\_\_\_\_ Parent/Guardian Signature

\_\_\_\_\_ Home Phone

\_\_\_\_\_ Emergency Phone

## THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER

*Please note: ONLY ONE MEDICATION PER FORM.*

*By WAC's, school staff are ONLY authorized to administer oral medication, asthma inhalers and EpiPens.*

Diagnosis or condition for which medication is given:

Method of administration:  oral tablet/capsule  oral liquid  asthma inhaler  nebulizer  EpiPen

Name of medication and dose:

Time of administration for DAILY medication:

If given AS NEEDED, specify length of time between doses and indication for usage:

- For an inhaler or EpiPen ONLY, this student may carry and is capable of self-administration.

- Oral medication for a 6<sup>th</sup> – 12<sup>th</sup> grades ONLY: This student may carry and self-administer a single dose per day of this medication. (Carrying and self-administration of controlled drugs is never allowed at school.)

Possible side effects of medication:

Emergency procedure in case of serious side effects:

This authorization is valid:  For the current School Year; or  From \_\_\_\_\_  To \_\_\_\_\_

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated, as there exists a valid health reason that makes administration of the medication advisable during school hours.

\_\_\_\_\_ Date

\_\_\_\_\_ Health Care Provider Signature

\_\_\_\_\_ Health Care Provider Name (PRINT)

Please see reverse side for Required Guidelines on Providing Medication for School Administration.

Adapted from The Administration of Medication in Schools; RCW 28A.210.260, 28A.210.270, 28A.210.370 5/07



## PROVIDING MEDICATION FOR SCHOOL ADMINISTRATION

Whenever possible, medication for students should be scheduled to be given during non-school hours. For those who need prescription or over the counter medication at school, the following is required by Washington State Law and/or school district policies and procedures in order to protect both the student and the school. Students may not carry on their person any prescription or over the counter medication, except as explained in numbers 8 and 9 below.

1. **Who can prescribe medication:** Health care providers who may authorize medication administration at school within their prescriptive authority include: medical doctor (M.D.); osteopathic doctor (O.D.); dentist (D.D.S.); advanced registered nurse practitioner (ARNP); or physician assistant (P.A.).
2. **Required form that must be provided each school year:** Authorization for Administration of Medication at School forms are valid for the current school year only. The forms must be completed and signed by both a parent/guardian and health care provider before medication can be dispensed to a student by trained staff, or carried and self-administered by students. A signed form must be on file for both prescription and over the counter medication, one form per medication. If the dosage changes, a new form is required.
3. **Delivering medication to the school office:** Medication to be kept in the health room for students or for field trips must be delivered to the school office by a parent/guardian or other designated adult. All medication must be counted by the school secretary, witnessed by a parent/guardian/designated adult.
4. **Required medication containers:** Medication must be in the original prescription bottle, or original over the counter container, with a current label. Do not send medication to school in an envelope or baggie.
5. **Required medication labels:** Prescription medication, including asthma inhalers, must be labeled by the dispensing pharmacy with the student's name, name and dose of medication, and the time to be given.
6. **Medication that can be legally dispensed by trained school staff:** Schools are authorized to dispense oral medication, asthma inhalers and EpiPens only. School staff may not dispense eye or ear drops, nasal inhalers or topical medication. Parents may bring medication to school and give it to their child themselves.
7. **Medication left at the end of the school year:** Medication remaining at the end of the school year will be discarded unless it is picked up by the parent/guardian within five days of the end of school. Medication will not be sent home with the student.
8. **Self-carrying / Self-administration of medication may be allowed for students in grades 6-12 ONLY, if the following occur:** 1) the health care provider and parent/guardian indicate permission to carry/self-administer on a current Authorization for Medication at School form; 2) the student may carry only a single dose per day of the medication in an original, labeled medication container; 3) approval is granted by the principal and RN health consultant. **Carrying and self-administration of controlled medication as defined by the FDA is never allowed** (for example, medication to treat ADD/ADHD, and most prescription pain medication). Permission to carry and self-administer the medication may be revoked by a principal after consultation with the RN and parent/guardian if the student demonstrates inability to responsibly possess and self-administer it.
9. **Self-carrying / Self-administration of asthma inhalers and EpiPens:** See CSD Policy/Procedure 3419. Summary: Authorization for Administration of Medication at School forms for inhalers and EpiPens will be valid for the current school year only. The student will demonstrate to the prescribing health care practitioner and an RN at school the skill necessary to use the medication appropriately. A student's authorization to carry and self-administer medication for asthma or anaphylaxis may be limited or revoked by the building principal after consultation with the RN and parent/guardian if the student demonstrates an inability to responsibly possess and self-administer the medication.