DATE 3-13-2020

Paperwork for Science Camp Overnight
DUE BACK TO MRS. OLENCHALK BY MARCH 30, 2020

Parents of Fifth Graders!
Attached is the paperwork for the 5th grade, April 14 & 15, 2020 overnight to Sierra Outdoor School.

THIS FORMS MUST BE FILLED OUT FOR YOUR STUDENT:
Sierra Outdoor School Enrollment & Health Form

FILL OUT AND RETURN **IF NEEDED** BY YOUR STUDENT:
Sierra Outdoor School Special Meal Form
Columbia School Medication Form

Please return this completed packet (stapled together) to Mrs. Olenchalk.

The Columbia PTA generously funds this field trip and we are grateful to them! This is the 6th year they have done this for 5th grade. We are asking for a **$50 per student donation** to help with the cost. Please make checks payable to "Columbia Elementary School" and note your student's name in the memo line. Please return to school with the paperwork.
The total cost of this field trip is $147.00 so your donation really helps towards the cost of going.

****** THE $50.00 IS A DONATION. EVERY STUDENT GOES, EVEN IF THEY CANNOT MAKE THE DONATION.**

If you have any questions about this packet, please call me (Mrs. Olenchalk) at 533-7700 ext. 231.

As we get closer to the trip, a suggested packing list and list of things not allowed will be sent home. And a school (Columbia) field trip form.

Thank You!!!

Mrs. Olenchalk & Mrs. Edward, 5th. grade

Check out where we are going!!!! Look at the website below!
Sierra Outdoor School www.sierraoutdoorschool.com

Fill Out

Clovis Unified School District
Sierra Outdoor School

15700 Old Oak Ranch Road
Sonora, CA 95370
(209) 532-3691 phone

School ______________________
Attendance dates from ______ to ______

ENROLLMENT AND HEALTH FORM

Name of child ____
First Middle Last

Address ____
Street City Zip

Name of Parent/Guardian ____

Telephone: Home____________ Work ______________ Relative or Friend ______________________

SPECIAL PHYSICAL LIMITATIONS WHICH SHOULD BE KNOWN TO CHAPERONES AND CAMP DIRECTOR:

Diet problems ☐ Asthma ☐ Recent Surgery/Illness ☐ Allergies ☐ Heart Condition ☐

Recent Broken Bones / Sprains ☐

If any of the above are marked, please specify ____

Name and address of Physician ____

Has your child been exposed to a communicable disease within the past three weeks? Yes ☐ No ☐

If yes, what disease? ______________________ Date he or she was exposed ______________________

In order to protect children from possible embarrassment, the following information is necessary.
Does your child walk in his/her sleep? ______ Wet the bed at night? Are there other factors that might affect the care of your child? ____

IF YOU CAN'T BE LOCATED IN CASE OF AN ACCIDENT, WHO SHOULD BE CALLED?

Name ______________________ Phone ______________________

Address ____

Has your child had his/her tetanus series or booster? ________ If so, what date? ______________________

INSURANCE COVERS ACCIDENTS ONLY, NOT ILLNESS. IN THE EVENT OF ILLNESS, IS YOUR CHILD COVERED BY A HEALTH INSURANCE POLICY? IF YES, PLEASE FURNISH US WITH THE FOLLOWING INFORMATION:

____
Name of Insurance Company Policy Number

If child is covered by Medi-Cal (up to date) ____
Card Number

Child's Date of Birth ______________________

IN THE EVENT OF ACCIDENT OR ILLNESS, CLOVIS UNIFIED SCHOOL DISTRICT DOES NOT ACCEPT RESPONSIBILITY FOR PAYMENT. PARENTS WILL BE CONTACTED. CHILD WILL BE TREATED ONLY WITH PARENTAL PERMISSION. PARENTS WILL PAY FOR TREATMENT IF THERE IS NO INSURANCE.

If a serious emergency arose, it might be necessary for a physician to attend your child before the camp administration staff could get in touch with you. Such care can be provided **only** if you sign the following AUTHORIZATION FOR MEDICAL TREATMENT. These statements below must be signed before your child can be accepted at the Sierra Outdoor School.

AUTHORIZATION FOR:

TETANUS SHOT/BOOSTER - I hereby give my permission to the Sierra Outdoor School to authorize a tetanus shot or booster if deemed advisable by a physician at Sonora Regional Medical Center.

Signature ______________________

MEDICAL TREATMENT - I hereby authorize the Sierra Outdoor School to provide medical or surgical care, including care rendered through the facilities of Sonora Hospital in any emergency which may occur while he/she is attending the Outdoor Camp.

Signature ______________________

It is understood that still and motion pictures may be made of this child as a participant in the program and permission is hereby given for the release of said pictures for such purposes as designated by the Director of the Sierra Outdoor School. Parents and/or Legal Guardians hereby give ~~consent for the above named child to participate in all activities under the direction of the Sierra Outdoor School staff, including transportation to and from~~ the location of the program and field trips which are part of the program.

Signature of Parent or Guardian ______________________

PLEASE RETURN THIS FORM TO THE SCHOOL YOUR CHILD ATTENDS

SIERRA OUTDOOR SCHOOL

SPECIAL MEAL STATEMENT FOR PARTICIPANTS WITH **ALLERGIES, CHRONIC DISEASES, DISABILITIES** OR VEGETARIAN REQUIRING SPECIAL MEALS

ıme of Participant	(2) Age	(3) School

(4) Name of Parent, Guardian or Authorized Representative	(5) Telephone Number

(6) Must Check One:

_____Participant is disabled or has a medical condition and *requires* a special meal or accommodation. **A licensed physician must sign this form.**

_____Participant is not disabled, but is *requesting* a special meal or accommodation. An example may include a food intolerance. However, food preferences are not included as an example. **A licensed physician, physician's assistant, or registered nurse must sign this form.**

_____Participant is **vegetarian.**

(7) Disability or medical condition requiring a special meal:

____

____

(8) Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation):

____

____

____

Foods to be omitted and substitutions: Please list specific foods to be omitted and suggest substitutions. You may use the back of this form for additional information.

(9) Foods to be omitted:	**(10) Suggested substitutions:**

(11) Signature of Preparer*		
(12) Printed Name of Preparer	(13) Date	(14) Telephone Number
(15) Signature of Medical Authority*		
(1‸ Printed Name of Medical Authority	(17) Date	(18) Telephone Number

*Physician's signature is required for meal changes to be made for participants with food allergies, intolerances or chronic diseases. For **vegetarian** meals, parent or guardian signature is required.

Fill out if needed. Return to Mrs. O.

Fill this out if your child needs it.

Columbia Elementary School

REQUEST FOR MEDICATION IN SCHOOL

Education Code 49423: Notwithstanding the provision of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parents or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

<u>WHENEVER POSSIBLE, MEDICATION SHOULD BE GIVEN AT HOME, BEFORE AND AFTER SCHOOL, PROVIDING THIS MEETS WITH THE PHYSICAN'S APPROVAL.</u>

<u>PARENT/GUARDIAN STATEMENT:</u>

1. I am the parent/guardian of the pupil named above. I am giving permission to and requesting school district personnel to assist this student with medication as prescribed by the physician.
2. The medication will be sent in the original prescription container with the pharmacy label stating physician's complete instructions for administering the medication.
3. The school and the physician may exchange information regarding the student's medication and medical condition.
4. (I) (We) the parent (s) of the undersigned student, hereby indemnify and hold harmless from any demands, claims, actions, suits, or any nature or kind, any and all personnel, employees and agents of said district who may act pursuant to the above instructions or pursuant to the instructions of the child's physician.

X______________________________ X______________________________
Signature of Parent or Legal Guardian Date

X______________________________ X____ X______________________________
Student Name Grade Date of Birth

PHYSICIAN'S STATEMENT:
The above named student is currently under my care and is receiving medication (s) for the following condition(s):

<u>MEDICATION (S) TO BE ADMINISTERED AT SCHOOL DURING SCHOOL HOURS:</u>

Drug ________________ Dose ________________ Amount ________________

Time ________________ Method ______________________________

Adverse reactions ______________________________________

Physician's Signature: ______________________________________

Must be filled out ↑