LA CAÑADA HIGH SCHOOL

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9-12 Principal

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Field Trip Rules and Expectations

In order to maintain a safe learning environment for all students, the following procedures are expected from all students, LCUSD staff and chaperones on overnight field trips.

1. All field trips must begin at the school site. All LCUSD staff, students and chaperones shall be transported as a group using the same mode of transportation. All LCUSD staff, students and chaperones may be checked/searched for illegal, unauthorized or controlled substances prior to participating in the activity (including but not limited to a potential canine search). Security and/or administrative designees or authorized agencies contracted with LCUSD may conduct searches on any person and/or their property in order to participate in the activity/trip. Any person who refuses to comply to a check/search will not participate in the activity trip.
2. Students will not use alcohol and/or illegal drugs and tobacco products at any time during the trip. When directly supervising students, LCUSD staff and chaperones shall model consistent behaviors.
3. If students require prescription and/or over the counter medications during the trip, parents/guardians must register this information with the school health clerk at least one (1) week prior to trip departure. This includes the appropriate district paperwork, signed by the prescribing physician with specific information regarding time of day, how much, etc. The certificated staff member will be given a list of students within the group with copies of the district form which includes clear instructions and the LCUSD staff member will be in charge of and will keep all prescription medications with them. Prescription medications MUST be held by the LCUSD staff member for the entire trip. At the conclusion of the trip, medications may be signed for and picked up from the Health Office at the school site or returned to parents by the staffmember.
4. Students shall be under the supervision of a LCUSD certificated employee plus other approved chaperones at least 21 years of age.
5. The ratio of students to adults shall not exceed ten pupils per adult. Students shall be under direct supervision of chaperones. Chaperones will be assigned to specific student groups. If "free time" is delineated in the itinerary, students shall be accessible to their immediate chaperone via electronic communication.
6. Chaperones shall be scheduled to work shifts during the "Lights Out" portion of evening supervision, usually from 11:30 p.m.- 5:00 a.m. Room checks shall be conducted to make sure students are in their correct rooms at all times and to ensure appropriate conduct. Chaperones shall monitor rooms and hallways throughout the evening to ensure student safety.
7. Chaperones must stay in the same facility as students on all overnight field trips, and on the same floors when possible.
8. A detailed itinerary shall bepre-approved by district personnel and/or the LCUSD Governing Board and followed by all on the trip.
9. Student behavior contracts shall be signed by all students and parents/ guardians.
10. Students who do not follow ALL field trip rules and behavioral expectations according to the LCUSD discipline policies may be sent home at the parent's/guardian's expense.
11. For trips where student pick-up takes place in a location other than the school site, an adult chaperone must remain at the pick-up location until all students have been released to parents or designated adult.
12. All other required field trip forms are in full force & effect. The above Field Trip Rules and Expectations are in addition to, but not limited to, the Off Campus Activity Permission Slip and Medical Authorization form.

I understand these rules and expectations and agree to abide by all rules set forth by the school, district, school staff and chaperones.

Student/Chaperone/Staff Member Name(Please print.)	Signature
Parent/Guardian Name if the student is attending (Please print.)	Signature

I am a ☐ student ☐ chaperone ☐ LCUSD Staff Member.

La Cañada High School

Off Campus Activity Permission Slip and Medical Authorization
(To be completed by Parent, Guardian, and Caregiver)

Dear Parents:

To allow your student to participate in the following school activity off campus, we need you to fill out the following information. Please fill out each section that applies to the type of activity your student wishes to attend.

TO BE FILLED OUT FOR ALL OFF-CAMPUS ACTIVITIES

This is to certify that my child/ward:

Name of Student | Student Cell Phone Number

has my permission to participate in the following activity

Time & Date of Activity: 9-12 Band & Orchestra to New York City, March 20-24, 2022

High School Adult Sponsor / Teacher: Mr. Jason Stone, Ms. Jennifer Munday, Mr. Mark Evans

Parent signatures are the teacher's authorization to administer emergency First Aid and/or to call any reference listed below in case of emergency, and to authorize a representative of the La Cañada Unified School District and/or the alternates listed below to act as agent(s) to consent to any X-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care deemed advisable and rendered by any licensed physician, surgeon or dentist whether in his office or in a licensed hospital. This authorization is given in advance of any required care to empower a representative or official of the District to give consent for such treatment as the physician may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of the State of California and is effective unless revoked in writing. I understand that if this trip involves payment to a travel agency, the La Cañada Unified School District will not be held responsible should political events force cancellation of travel and loss of trip payments.

Please print below:

Parent Name | Address:

Home Phone | Work Phone | Cell Phone

Additional Emergency Contact. | Phone #

Family Physician | Phone #

Pupil's Medical Insurance Carrier:

Policy Number:

Private Transportation Authorization

If it is necessary to use a private car rather than a bus to transport students, the following must be signed:
My student has my permission to ride in a private car driven by a teacher or parent to the above mentioned activity.

Signature | Date

WAIVER AND MEDCIAL AUTHORIZATION

We (I) are (am) aware and acknowledge that any activities covered by this permission slip, by their nature, pose the potential risk of injury/illness to the individuals who participate. For and in consideration of the opportunity for our (my) child/ward to participate in those activities, we (I) do hereby agree as follows:

1. All persons making the field trip or excursion shall be deemed to have waived all claims against the District or the State of California for injury, accident, illness or death occurring during or by reason of the field trip or excursion, including but not limited to transportation to and/or from the field trip/activity.

2. That we (I) are (am) solely financially responsible for any cost and/or all indebtedness incurred as a result of any emergency and/or routine medical and/or surgical treatment and services prescribed by the attending physician for my child/ward, including all charges not covered by insurance.
3. To indemnify and hold harmless the La Canada Unified School District, its officers, employees, agents, representatives, and volunteers from each and every claim or demand made, and each and every liability, action, loss, debt, or damage which may arise by or in connection with, or result from, any routine and/or emergency medical services, or participation of our (my) child/ward in the field trip/activity covered by this permission slip, including but not limited to transportation to and/or from the field trip/activity.
4. We (I) fully understand that all persons participating in the field trip/activity are to abide by all rules and regulations governing conduct during the trip. Any violation of these rules and regulations may result in the individual being sent home at the expense of his/her parent/guardian.
5. If our child/ward has a special medical condition and/or physical disability diagnosed by a physician, a description of that medical condition and/or physical disability is attached hereto.

STUDENT MEDICAL INFORMATION

☐ My child/ward has a medical condition and/or physical disability that District should be aware of.

Specify condition _____

☐ My child/ward is allergic to the following medications: _____

☐ My child/ward must take medication while participating in the activities covered by the permission slip.
*List medication that your child/ward must take while participating in the activities covered by this permission slip.

Name of Medication	Dosage	Time	Reason

Note:

1. All medications (over the counter & prescription) taken by your child/ward while participating in the activities covered by this permission slip must be prescribed by a physician and listed on the attached medication form.
2. All medication prescribed by the physician for your child/ward must be kept/administered by District staff.

We (I) acknowledge that we (I) have carefully read this Pupil Field Trip Permission Slip and Medical Authorization form and we (I) understand and agree to its terms.

_____ _____

Signature of a parent/ guardian Date

_____ _____

Signature of a parent/ guardian Date

(Both parent must sign unless one parent has sole custody)

*****Please note:**

All students must return <u>both forms</u> to participate in the off campus activity.
<u>*Parent signature is required on the attached medication form</u> even if no medications are requested.**

Note: This form must be kept with the teacher for the entire activity, with a copy on file at the school site.

La Cañada High School

REQUEST FOR MEDICATION TO BE TAKEN DURING OFF CAMPUS ACTIVITY

ALL PARTICIPANTS MUST SUBMIT THIS FORM.

IF NO MEDICATION IS REQUESTED PARENT CHECKS NO AND SIGNS SECTION

Section I: To be completed and signed by parent or guardian.

Print Name (Last, First)	Sex	Birth Date
	☐ Male ☐ Female	
☐ NO over the counter or prescription medication requested. (Check the box, sign below in Section I and return this form.)		
☐ Yes, medication required/requested. I request that my student (named above) be assisted by authorized persons in taking these described medication while participating in voluntary trip from (dates) to . I understand that ALL medications will be administered in compliance with the school's policies. If "Yes" is checked, your physician must sign below.		
Signature of parent or guardian	Cell Phone Number	Date Signed (Month/day/year)

Section II. To be completed and signed by a physician (See below).

	Name of Medication	Name of Medication	Name of Medication	Name of Medication
Purpose of Medication				
Dosage Prescribed				
Dose From (Tablet/Liquid, etc.)				
Time to be Administered				
Precautions, special instructions, possible adverse effect(s) or comments:				

Section III. To be completed and signed by a Physician if any medication is requested.

Medication listed below will be available if authorized by parent and physician, as shown by both required signatures on this form. Please indicate your approval for use of these medications by checking the appropriate box before each medication.

Yes	No		
☐	☐	Medication & Dose Form Indications for use: Dosage & frequency:	**Tylenol 325 mg. Oral Tablets** Fever reduction for oral temperature above 101 F. Relief of headache or minor ache/pain. One tablet every 4 - 6 hours as needed, not to exceed 5 doses in 24 hours
☐	☐	Medication & Dose Form Indications for use: Dosage & frequency:	**Polysporin** Topical antibiotic to prevent infection in minor cuts or abrasions Small amount to affected area, applied 1 - 3 times daily
☐	☐	Medication & Dose Form Indications for use: Dosage & frequency:	**Hydrocortisone 1% Cream** Relief of itching and pain associated with allergic itches, rashes and insect bites Small amount to affected area not to exceed more than 4 times daily

Print Name of the Physician		The above named student for whom the above medication is prescribed under my care.
Physician's License Number	Physician's Telephone Number	Signature of Physician
Address (Street, suite/room, city, zip code)		Date Signed (month/day/year)