EXHIBIT C

Boerke _____
Teacher's name

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
PARENT PERMISSION AND RELEASE OF LIABILITY FOR
STUDENTS PARTICIPATING IN TRIPS

_____, a student at Memorial High _____ School,
Student's name School

has my permission to travel via school-arranged transportation to Clear Lake HS _____
Location

on 2-16-2019_____, departing at 6:00 am ___ and returning at 11:00 pm ___
Date Time Time

to participate in Crowd Pleasers dance competition _____.
Activity

I understand that students on trips are subject to school rules, including the student/parent handbook, SBISD Discipline Management Plan and Student Code of Conduct, concerning dress and conduct, and that failure to abide by these regulations may result in disciplinary action. **Failure to follow these regulations may result in a student being sent home immediately at the parents' expense.**

I hereby release the Spring Branch Independent School District (SBISD) and all its supervisors, employees, volunteers, and/or representatives from any and all liability and/or claims and/or cause of actions individually or collectively, for any damages or injuries that might be received during class activity, on trips, or while traveling to and from such trip destinations, except for those for which SBISD, its supervisors, employees, volunteers, and/or representatives have effective insurance coverage but only to the extent of such insurance coverage.

In order to participate in this trip, each student must have written permission from the parent or guardian.

Please sign below to grant permission for your child to go on this trip.

_____ _____
Signature of parent or guardian Date

Special health or dietary needs: _____

_____

In case of emergency, please contact:

_____ _____
Parent or guardian name (printed) Phone number

_____ _____
Name (printed) Phone number

The teacher or sponsor will attach the most current Medical Authorization Form for Trips to this document. (Parents: Please keep this information updated

EXHIBIT E

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
MEDICAL AUTHORIZATION FORM FOR TRIPS

This section is to be completed by Trip Sponsor:

This document will be presented to appropriate personnel at such time as emergency medical, dental, surgical care, or hospitalization may be required.

Closest medical facility to event: EmergiCare _____

Address: 2409 Falcon Pass #100, Houston, TX 77062____ Phone: (281) 461-1111 _____

I / We, being the parent(s) or legal guardian(s) of _____, a minor, do hereby appoint an agent of SBISD from _Memorial High _____ School
Campus

to act in my/our behalf in authorizing emergency medical, dental, or surgical care and hospitalization for the above-named minor during a period of my absence. This authorization is given with my/our understanding that attempts will be made to contact me/us prior to the administration of treatment for any nonlife-threatening situation/condition utilizing the contact information that I/we have provided.

_____ _____
Signature of parent or guardian | Date

_____ _____
Address | City/State/Zip

_____ _____
Home phone | Daytime phone (Where you can be reached during the trip)

Hospitalization Coverage for the Above-Named Minor

_____ _____
Name of insurance company or government center | Identification or group number

_____ _____
Family physician's name | Family physician's phone number

Insurance Waiver Statement

(Complete this section if you do not have insurance)

Where no proof of insurance is established, it is understood that the parents of the student must assume legal responsibilities for expenses incurred for injuries to students that occur during cocurricular activities. I have read and understand the above.

_____ _____
Signature of parent or guardian | Date

_____ _____
Student's name | Teacher

EXHIBIT G

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
CHAPERONE-SPONSOR EMERGENCY INFORMATION

Please print or type only.

Name of sponsor _____ Organization/Club _____

Home address _____ City _____ State _____ Zip _____

Date of birth: _____

Please list persons who can act on your behalf in case of an emergency.

Name _____ City _____ State _____

Relationship to sponsor _____ Phone ( ) _____

Name _____ City _____ State _____

Relationship to sponsor _____ Phone ( ) _____

Name _____ City _____ State _____

Relationship to sponsor _____ Phone ( ) _____

Hospitalization Coverage for the Above-Named Chaperone-Sponsor

Name of insurance company or government center _____ Identification or group number _____

Family physician's name _____ Family physician's phone number _____

Insurance Waiver Statement

(Complete this section if you do not have insurance)

Where no proof of insurance is established, it is understood that the chaperone-sponsor must assume legal responsibilities for expenses incurred for injuries that occur during trips. I have read and understand the above.

Signature of chaperone-sponsor _____ Date _____

EXHIBIT I

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT HEALTH SERVICES: MEDICATION / SPECIAL PROCEDURE ADMINISTRATION RECORD

Student's name: _____ Grade: _____ Destination: Clear Lake HS _____

School: Memorial HS _____ Teacher: Boerke_____ Trip/Activity date: 2-16-19__

Copies in Trip Folder:

☐ Emergency care plan ☐ Clinic emergency card ☐ Procedure protocol(s)

IMPORTANT: The signatures below acknowledge release/acceptance of medication(s) listed for the student noted above.

_____ Signature of RN/NA releasing medication	_____ Date	_____ Time
_____ Signature of trip leader accepting medication	_____ Date	_____ Time
_____ Signature of trip leader returning medication	_____ Date	_____ Time
_____ Signature of RN/NA noting return of medication	_____ Date	_____ Time

Medication Administration and Special Health Procedure Roster

Important: Unlicensed personnel must be trained by licensed health services staff according to District-approved protocols before administering medications or performing special health-care procedures. Dosage instructions for administering medication(s) must be taken from the Medication Administration Card packaged with each medication. Signatures are required below for each medication administered and procedure performed.

Medication: _____ Time to be given: _____

Signature of person administering medication: _____ Date/Time: _____

Medication: _____ Time to be given: _____

Signature of person administering medication: _____ Date/Time: _____

Medication: _____ Time to be given: _____

Signature of person administering medication: _____ Date/Time: _____

Procedure: _____ Time: _____ Frequency: _____

Signature of person
administering medication/procedure: _____ Date/Time: _____

Procedure: _____ Time: _____ Frequency: _____

Signature of person
administering medication/procedure: _____ Date/Time: _____

Procedure: _____ Time: _____ Frequency: _____

Signature of person
administering medication/procedure: _____ Date/Time: _____

Medical alert notes/special instructions: _____

_____

_____

_____

Return to Campus Health Services staff