

STUDENT ACTIVITIES  
TRAVEL

FMG  
(EXHIBIT)

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 Los Angeles, California \_\_\_\_  
Location

on 2/28/19-3/3/19 \_\_\_\_\_, departing at 5:00 am \_\_\_\_ and returning at 10:00 pmm \_\_\_\_  
Date Time Time

to participate in Markette trip to LA to take dance classes from industry professionals \_\_\_\_\_.  
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: Urgent 9 – Urgent Care Center \_\_\_\_\_

Address: 1000 N Central Ave, 140, Glendale, CA 91202\_\_ Phone: (818) 662-7000\_\_\_\_\_

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 I

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

Student's name: \_\_\_\_\_ Grade: \_\_\_\_\_ Destination: LA, California \_\_\_\_\_

School: Memorial High School \_\_\_\_\_ Teacher: Boerke \_\_\_\_\_ Trip/Activity date: 2/28-3/3/19

*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.

<b>Medication:</b> _____	<b>Time to be given:</b> _____
Signature of person administering medication: _____	Date/Time: _____
<b>Medication:</b> _____	<b>Time to be given:</b> _____
Signature of person administering medication: _____	Date/Time: _____
<b>Medication:</b> _____	<b>Time to be given:</b> _____
Signature of person administering medication: _____	Date/Time: _____

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<b>Procedure:</b> _____	<b>Time:</b> _____	<b>Frequency:</b> _____
Signature of person administering medication/procedure: _____		<b>Date/Time:</b> _____
<b>Procedure:</b> _____	<b>Time:</b> _____	<b>Frequency:</b> _____
Signature of person administering medication/procedure: _____		<b>Date/Time:</b> _____
<b>Procedure:</b> _____	<b>Time:</b> _____	<b>Frequency:</b> _____
Signature of person administering medication/procedure: _____		<b>Date/Time:</b> _____

Medical alert notes/special instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Return to Campus Health Services staff*