HIGH BRIDGE SCHOOL DISTRICT

HIGH BRIDGE ELEMENTARY SCHOOL
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HIGH BRIDGE MIDDLE SCHOOL
50 Thomas Street
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Gregory A. Hobaugh, Ed.D.
Superintendent
Elementary School Principal

Emma A. Alparone
Elementary School
Assistant Principal

Lisa M. Fallon
Supervisor of Special Education

Richard J. Kolton
Middle School Principal
Director of Curriculum and
Technology

September 20, 2019

Dear Parents/Guardians,

On Tuesday, October 1st, with a rain date of Thursday, October 4th, the 6th grade students will be going on a riverboat on the Delaware River to do STEM activities and learn about local history. The students will learn the chemistry of the river, birding class/watershed stewardship, learn how steam engines work, they will also learn about aquatic insects and do a walking tour of the D & R Canal. **The cost of this trip is $34.00**, the price includes the bus and admission. Students should bring a bagged lunch and a drink, should dress for the weather and wear sneakers. **Please send in the bottom portion of this form along with payment by Friday, September 27th. Checks made payable to the High Bridge Middle School. If your child will need any medication during this trip please complete the attached medication authorization form.** Any questions or concerns regarding your child's medical needs please contact Mrs. Lynn Gresko.

Sincerely,

Ms. Jemma Buccine- Math and Enrichment Teacher

Splash permission forms are due by **Friday, September 27th.**

____________________________has permission to travel by bus and attend the SPLASH on the Delaware on Tuesday October 1, 2019 or Thursday October 4, 2019

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Parent/Guardian Signature	I may be reached at (phone number)
Name of Emergency Contact Person (Other than Parent/Guardian)	Emergency Phone #

Any medical concerns please complete the information on the following form.

High Bridge Middle School
Class Trip Medication Authorization for Prescription or OTC Medications

Form & medicines are due one week before trip. One sheet for each medication.
All items must be completed or this form will be returned to you for completion. Please write clearly.

This form is NOT for those who already have Epi Pen, Asthma Plan or any other orders on file this school year. *We will follow your previously submitted doctor's orders for the class trip. Contact nurse with any questions.*

M.D., D.O., P.A. or A.P.N, please complete: Medication Order

State law requires a signed prescription by the physician that includes the information listed below OR completion of the form below. If a prescription is faxed, the original must be forwarded to the Health Office.

Student's Name_______________________________ DOB________ Date__________

Diagnosis____

Name of Medication ____

Dosage______________________________Times_____________ Route_________

Possible Side Effects____________________________ Termination date____________

______The student is free of contagious disease and is physically fit to attend school and this trip.
Initial

______The student would not be able to attend this trip unless the medication is given during school hours.
Initial

______________________________ ____________________________________
Physician's Signature Stamp (Required please)

Parent/Guardian, please complete: Consent for Giving Medication in School

I request and give my consent for the Nurse for the HBMS class trip to administer the following medications to my child during this trip:

Trip Date________________ Trip Location_____________________________
Name of medication ____
Amount to be given____
Dates to be given____

Parent initial__________ The medication is to be furnished by me in the original pharmacy container, labeled with the student's name, date of prescription, name of medication, dosage and the prescribing physician's name
Parent initial__________ I understand that any medication not picked up by me will be disposed of on last day of school.
I give permission for the above information to be shared with appropriate staff members, coaches and trip chaperones for the safety and welfare of my child. ___Yes ___No

_________________________ __/__/____ _________________________ __/__/__ _________________________
Signature of parent/guardian Date Signature of school nurse Date Signature of trip nurse

For school use
Medication amount received____________________ Date received___/___/____ Initial, R.N.______
Date returned to parent ____/___/_____ Initial, R.N. __________

Record of Medication Administration on School Trip

Date	Time/Initial	Time/Initial	Time/Initial	Time/Initial	Notes

Greskol class trip med form