HIGH BRIDGE SCHOOL DISTRICT

HIGH BRIDGE ELEMENTARY SCHOOL
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HIGH BRIDGE MIDDLE SCHOOL
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Superintendent
Elementary School Principal

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Elementary School
Assistant Principal

Lisa M. Fallon
Supervisor of Special Education

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

September 17, 2019

Dear Parents/Guardians,

On Friday, October 18, 2019, the 5th grade will be going to Liberty Science Center in Jersey City. During their visit they will explore the centers many interactive and hands on exhibitions. Students will also spend time in the Jennifer Chalsty Planetarium which is the biggest planetarium in the Western Hemisphere. In the planetarium students will explore earth and space science concepts using the current night sky above New Jersey.

The cost of this trip is $34.00, the price includes the bus and general admission into the center and a program in the planetarium. Students should bring a bagged lunch and a drink as they will be eating in one of the group dining rooms at the center. **Please send in the bottom portion of this form along with payment by Friday, October 4th. 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,

Mr. Mike Doerwang and Mrs. Caryn Snyder 5th Grade Teachers

Liberty Science Center permission form are due by **Friday, October 4th**.

_____ has permission to travel by bus and attend the Liberty Science Center on Friday, October 18, 2019.

_____ _____

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 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