6th Grade Outdoor Education Camp
September 18th-19th, 2018

Parents and Caregivers:

Meadow Ridge 6th grade camp will be Tuesday, September 18th through Wednesday, September 19th. We are getting excited about this great outdoor educational experience, and we hope that your son or daughter is feeling the energy as well.

On September 18th, after arriving at school at 9:00 AM, the kids will be off to Camp Lutherhaven (located near Coeur d'Alene) by 9:30. We'll arrive at camp sometime around 10:45 AM. We'll be back to school on Wednesday, September 19th, around 3:00 PM.

The **total** for a student attending camp will be $55.00, and an adult chaperone will pay $20.00. (Need-based scholarships are available). Please send a check payable to Meadow Ridge ASB. The camp fee covers meals, overnight expenses, and transportation. Please return signed camp forms by September 7th. Payment is due by September 13th.

We are in need of adult chaperones for this tremendous event. Please consider lending a hand. All overnight chaperones will supervise the learning rotations and the cabins during our stay. There will be a chaperone meeting to finalize specifics with those who are able to help out on September 13th after the 6th grade open house.

Remember…Please return all authorization forms (signed) by Thursday, September 7th, 2018, and camp fees turned in by September 13th.

Thank you,
Meadow Ridge 6th Grade Team
monica.wallace@mead354.org bruce.hagstrom@mead354.org denise.crouch@mead354.org

Name: ______________________ Phone: ______________________

Your child's name: ______________________ email: ______________________

Please check any of the following ways you can help:

_____ **I would like to come as an overnight cabin chaperone for the entire camp experience.**

_____ **I am only able to come up in the evening after work, and I am able to stay overnight too.**

_____ **I would like to help out during the day only, supervising rotations, or in the dining room.**

_______**Tuesday** ________ **Wednesday**

Any comments/questions/concerns about chaperoning:

Policy 2152

Permission To Participate In School Trip - Elementary

After reviewing the information provided regarding this trip, I hereby grant permission to participate for:

STUDENT NAME ______________________ SCHOOL Meadow Ridge

TRIP PURPOSE 6th grade camp

TRIP DESTINATION Lutherhaven Camp TRIP DATE 9/18 - 9/19 2018

TRANSPORTATION: District Bus or vehicle Mead School Dist. Bus

Other (description) ______________________

ADDITIONAL NOTES: ______________________

____

TO BE COMPLETED BY PARENT (All bold faced items):

Please list any medical conditions of which school staff should be aware ______________________

____

Emergency Contact Number ______________________

I acknowledge that this activity entails inherent risks of bodily injury as well as damage to or loss of property. I hereby release the Mead School District , and its staff and representatives, from liability for such loss or injury as the result of this trip, to the extent allowed by law.

I certify that my child has no known medical or physical conditions which could interfere with his/her safety in this activity. In the event that it becomes necessary for the school district staff in charge to obtain emergency care for my child, I acknowledge that neither the school district or the individual staff member is responsible for the expense incurred as the result of the accident, injury, illness, or other unforeseen circumstance.

I authorize qualified medical and emergency professionals to examine, and in the event of injury or serious illness, administer emergency care to the above named student. I understand that an effort will be made to contact me to explain the nature of the problem prior to any treatment.

______________________ ____________ ____________

Signature of Parent/Legal Guardian **Date** **Phone**

TRIP INFORMATION (Attached)

I have read and reviewed with my child the attached itinerary (detailing dates, places, events, times, etc.) and behavior expectations. I am also fully aware of the special dangers and risks inherent in participating in these activities. Being fully informed as to these risks and expectations, we agree to abide by those expectations and participate in the event listed above.

______________________ ____________ ____________

Signature of Parent/Legal Guardian **Date** **Phone**

Camp Lutherhaven & Shoshone Mountain Retreat

Student Registration for Outdoor Education (Please Complete Both Pages)

Teacher's Name: ***Dates Attending:***

Name of School ______________________________ City/State ____________________

Name ____ Date of Birth __________
Last ***First*** ***Middle Initial***

_______Male _______Female

Address ____
Mailing Address

____
City ***State*** ***Zip Code***

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
Email

____
Home Phone ***Work Phone*** ***Cell Phone***

Custodial parent(s)/guardian(s) ________________________________
Name

Home address____
(if different from above) *Mailing Address* *City* *State* *Zip Code*

In case of emergency, we (I) can be reached by phone at:

Home phone ( ) Work phone ( )

<u>If we (I) are not available in an emergency, please contact:</u>

Name ____

Relationship ______________________ Phone (____________)______________

Address ____
Mailing Aaddress *City* *State* *Zip Code*

Medical Information

The following information is provided for any licensed physician, dentist, or hospital not having access to our (my) child's/ward's medical history

Medication Allergies ____

Food & Other Allergies ______________________ Date of last Tetanus shot _____|_____|_____

Family Physician ______________________ Phone (____)______________________

Family Dentist ______________________ Phone (____)______________________

Medication(s) currently being taken ______________________________________

____

Medical Insurance Company ____

Address ____

Insurance ID number ______________________ Group Number______________________

Description of any limitations or restrictions on camp activities______________________

Permissions & Liability Release

I have requested that Lutherhaven Ministries enroll my child/ward, as named above, as a participant in an activity-based camp, program or activity sponsored by Lutherhaven Ministries at one of its camps or sites. As a condition of participating in this camp, program or activity, I, the undersigned, do hereby agree on behalf of my child/ward, as named above, to the following:

Known & Unknown Risks

I understand that my child's/ward's presence at and participation in this camp, program or activity presents varying degrees of certain risks—some of which are unknown—which may arise from a condition of the premises at which the camp, program or activity is held; from an action of any person in connection with the conduct of any planned or unplanned activity; or from other unforeseen elements.

While it is understood that camp programs and activities are fully supervised by qualified staff whose goal it is to make every camp experience as safe as possible, I acknowledge that such known and unknown risks exist, I understand that my child/ward may incur personal injury or property damage while attending this camp, program or activity, and I fully and willingly agree to assume all risks associated with these activities on behalf of my child/ward.

Medical Release

I consent to first aid and emergency medical care for my child/ward and authorize, if necessary, admission to a hospital for treatment of injuries that my child/ward could sustain while participating in this program. I understand that I am responsible for any and all medical expenses that may be incurred by my child/ward, including emergency medical transport, as a result of any accident or illness while participating in the program. I give permission for Lutherhaven Ministries to provide transportation or arrange for transportation through Emergency Medical Services, if needed, for my child/ward for medical care.

Publicity Release

I agree to allow the use of my child's/ward's photos, quotes and/or likeness' in brochures, ads, web pages, video tape and other media as deemed useful by the camp for marketing purposes. I waive rights to any royalty or fees that might be applicable for the use of such images, quotes or likeness'.

Participant Name (please print)____

Parent/Guardian Signature ______________________ ______________________**Date** ______/______/______

Lutherhaven Ministries
Challenge Course Applicant Information & Release of Liability

Disclosure: Lutherhaven Ministries' Challenge Course and Rock Climbing Programs involve a variety of activities that may include warm-up activities, games, group problem solving initiatives, low and high course elements, climbing on natural rock faces, and potentially rigorous physical adventure activities. The level of participation in any Challenge & Rock Climbing Course activity is at all times completely up to the individual's choice. All Lutherhaven Ministries Challenge and Rock Climbing elements are built to the highest industry standards, and participants in any high elements are belayed by professional staff utilizing appropriate rope, harness and canopy systems. However, each participant must assume the risk that he or she may suffer an emotional or physical injury or disability while involved in a Challenge or Rock Climbing Course element.

Please complete this form completely: Certain health/medical information must be made known to the facilitator(s) conducting programs so that they are prepared to respond appropriately if health or emergency needs arise. This information will be held in confidence.

Name of Group ______________________________ Date ____________

1. Name ______________________________ Date of Birth __/__/__

2. Do you have health/accident insurance? _____ No _____ Yes If yes, name and address of company:
____

3. Do you have any limiting physical disabilities or handicaps (temporary or permanent)? _____No_____Yes If yes, identify and explain: ______________________________
____

4. Are you currently taking any medication (prescribed or otherwise)? _____ No _____Yes If yes, what are you taking and what condition is it for?

5. Do you have any allergies~~, reactions to medications, or any other medical limitations? _____No _____Yes If yes,~~ identify and explain: ______________________________
____

Release of Liability: I understand that parts of the Lutherhaven Ministries Challenge & Rock Climbing Course may be physically or emotionally demanding. I affirm that my health is good, and that I am not under a physician's care for any undisclosed condition that bears upon my fitness to participate in Challenge & Rock Climbing activities. I recognize the inherent risk of injury or disability in Challenge and Rock Climbing activities. I understand that each participant must assume the risk of physical injury that could result from any of these activities. I release Camp Lutherhaven, Shoshone Mountain Retreat, Lutherhaven Ministries, the Lutherhaven Ministries staff, Board of Directors and constituent congregations from all liability for any injury to me from participation in Challenge & Rock Climbing Course activities.

Date: ____________ Applicant's Signature (If at least 18 years old): ______________________________

Parent's or Guardian's Signature (If under 18 years old): ______________________________

Applicant's Address: ______________________________

Home Phone: ____________________ Business Phone: ____________________

Emergency Contact: ____________________ Phone: ____________________

Photo Release Lutherhaven Ministries may use, reproduce, assign and/or distribute photographs or videotapes of myself/my child for use in materials they may create for the purpose of promoting Lutherhaven Ministries and its programs.

Date: ____________________ Signature: ______________________________

HEALTH SERVICES

2323 E. Farwell Rd • Mead WA 99021 • Telephone (509) 465-6000 • Fax (509) 465-6020

HEALTH INFORMATION FOR 6TH GRADE CAMP

Dear Parents/ Guardians:

Please complete this form and return it to your child's teacher a week before camp.

If it is necessary for your child to take medication (prescription or over-the-counter) to camp, please complete the attached Medication Request form, which must be signed by both the parent and your health care provider. All medicines must be in the original container labeled with the student's name, medication name, dosage, and time to be taken. Prior to boarding the bus, all medication must be given to the first aid provider. Students are not allowed to be in possession of any medication while at camp. Exception: With written authorization on the Medication Request form, emergency medication (i.e. inhalers, EpiPens, insulin) may be self-carried and administered. While at camp, students are responsible for coming to the first aid provider at the time the medication is to be taken. Note: If your child already has a current Medication Request Form at school for the medication you will be sending, completing the attached Medication Request form is not necessary.

Student Name ______________________ Teacher ______________________

1. Will you be attending camp with your child? __________
2. Where can you be reached in case of an emergency?

   Name __________________ Phone number ____________ Cell ____________

   Name __________________ Phone number ____________ Cell ____________

3. Who can be contacted if you are not available?

   Name __________________________ Phone number __________________

   Name __________________________ Phone number __________________

4. Are there any diagnosed medical conditions? __________________________
5. List any medication you are sending and its purpose, the dosage, and time to be taken.

   ____

6. Are there any special diet problems? Please note special directions.

   ____

7. Does your child have any physical problems that should be noted? (Recent surgery, illness, broken bones, etc.)____
8. Does your child have any allergies? ______________ Asthma? ____________

   Please note special instructions______________________________________

9. The following information is needed to provide appropriate sleeping arrangements:

   Sleep Habits: Light _____ Heavy ______ Sleepwalk ______ Nightmares ______

   Bed Wetter (please check yes or no) Yes________ No______

10. Any additional comments: ______________________________________

HS-755
5/07

HEALTH SERVICES

2323 E. Farwell Rd • Mead WA 99021 • Telephone (509) 465-7600 • Fax (509) 465-7646

MEDICATION REQUEST FORM

Student Name:______________________________ Birthdate:______________

School:______________________________ Grade:______________

TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Name of Medication(s)	Dosage(s)	Reason for Medication(s)	Time(s) of Day To Be Taken

If given prn, specify the length of time between doses: ______________________________

Possible side effects of medication: ______________________________

____

Inhalers: This student has demonstrated, to a licensed health professional in my office, the ability to correctly administer this medication: ☐ Yes ☐ No

Student may carry inhaler on his/her person: ☐ Yes ☐ No

EpiPens: This student has demonstrated, to a licensed health professional in my office, the ability to correctly administer this medication: ☐ Yes ☐ No

Student may carry an EpiPen on his/her person: ☐ Yes ☐ No

Note: When a Nurse isn't available for assessment of a student experiencing anaphylaxis, **EpiPen will be the first treatment.**

Non-oral medication: Student is capable of self-administration: ☐ Yes ☐ No

I request/authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated above from ______________ to ______________ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by school personnel who have no formal medical education.

______________ Date of signature

______________________________ Signature (Licensed Health Professional with Prescriptive Authority)

Phone Number: ______________

Name: ______________________________ (Print or Type)

NOTE: This form MUST be signed by a licensed health professional with prescriptive authority.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to be above-identified student in accordance with the doctor's instructions for the period from ______________ to ______________ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed.

Permission to carry inhaler: ☐ Yes ☐ No
Permission to carry EpiPen: ☐ Yes ☐ No
Permission to self-administer non-oral medication: ☐ Yes ☐ No

Date of Signature______________ Parent/Guardian Signature______________________________

Telephone Number: (Home)______________ (Cell) ______________ (Work) ______________

MEAD SCHOOL DISTRICT

PARENT INFORMATION ON MEDICATION AT SCHOOL

Pursuant to Chapter 195, Laws of 1982 and Chapter 28A.210 RCW, Mead School District is authorized to administer oral or topical medication, eye drops, or ear drops to students during school hours. It is our policy that such medications will only be administered when the failure to receive the medication may result in the student being unable to attend school and/or well enough to participate in learning activities. We define medication to mean all drugs - whether prescription or over the counter. Medication must be brought to the school office by the parent/guardian/custodian and will be stored in a locked cabinet.

THE FOLLOWING CONDITIONS MUST BE MET:

I. Prescription Medication
1. All medication must have written orders. The medication request must be signed by a licensed health professional who has prescriptive authority.
2. All medication must have signed parent/guardian/custodian permission.
3. All medication must be in the original prescription bottle (container) and properly labeled with student's name, name of drug, dosage, name of health professional who is prescribing, and the time of day to be given.
4. Sample medication must also be properly labeled and in the original container or package.

II. Back-up Medication
1. Back-up medication for life threatening health conditions is highly recommended. (i.e. Epi Pens and inhalers)

III. Non-Prescription Medication
1. Non-prescription medication (i.e. cough drops, vitamins, aspirin, cough syrup or any over-the-counter medication) will not be given without written prescriptive orders plus signed parent/guardian/custodian permission.
2. Non-prescription medicine must be in the original container and must be labeled with the student's name, the prescribing authority, dosage, and time of day to be given.

IV. Non-Oral Medication
1. School personnel may administer eye drops, ear drops, ointments, & topical medication.
2. School personnel will NOT administer intranasal, rectal or injectable medication. These medications must be self-administered by the child or the parent/guardian/custodian, or an adult designee may come to school and administer the medication.
   Exception: Injectables in life-threatening situations (i.e. Epinephrine for Anaphylaxis)
3. If medication is self-administered, it must be indicated on the Medication Request Form.

V. Administering Medication
1. The school district form, Medication Request Form, must be completed and signed by a health professional prescribing within the scope of his/her prescriptive authority. This form is available at any school office.
2. The parent/guardian/custodian must fill out and sign the parent portion of the form.
3. This authorization is good for the current school year only.

What-To-Take List

PLEASE BE SURE TO LABEL EVERYTHING!

- ❑ WATER BOTTLE (labeled)
- ❑ SUITCASE OR BAG
- ❑ BEDDING (sleeping bag & blanket or equivalent)
- ❑ SHOES (appropriate for hiking)
- ❑ SHOES (any other type needed—NO FLIP FLOPS)
- ❑ SWEATSHIRTS (or several warm shirts)
- ❑ SHORTS (2 pair—appropriate school length)
- ❑ LONG PANTS (2 pair)
- ❑ SOCKS (at least 3-4 pair)
- ❑ UNDERCLOTHING (2 pair)
- ❑ SLEEPWEAR
- ❑ HEAVY JACKET OR COAT
- ❑ FLASHLIGHT
- ❑ BATH TOWEL/WASHCLOTH
- ❑ SOAP/SHAMPOO/TOOTHPASTE/COMB/TOOTHBRUSH
- ❑ HAT
- ❑ PLASTIC BAG (for dirty clothes)

PLEASE DO NOT BRING ANY OF THE FOLLOWING:

NO ELECTRONICS or GAMES (includes phones, ipods etc)
EXPENSIVE THINGS, OR ANTHING THAT COULD BREAK EASILY
NO GUM, NO WEAPONS & NO MONEY—there's nothing to buy at camp!