SkillsUSA District 2

**Permission Slip**

*Dorney Park • June 6th 2022*

I/we hereby grant permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First and Last Name

to attend and participate in the above activity. In case of an accident, injury or illness, I/we do hereby authorize the SkillsUSA or CTSO advisor to take the above named student to a physician or emergency room of a hospital. Since the health of the student is of paramount importance, it is imperative to know whether your child has any allergies, handicaps or other health problems of which the advisor should be aware. If so, please note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Work/Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print First and Last Name

Who can be reached if the parent/guardian is not available in case of illness or injury?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Work/Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print First and Last Name

Health Insurance Carrier Name/Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is strictly confidential Insurance Carrier Name Policy Number

I have read and agree to the attached code of conduct. If I withdraw or am sent home from this activity, I understand that my parent/guardian and I are responsible for the entire cost of the event

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Signature of Student Date

**Student Application Guidelines**

Student’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Technical Area:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Technical School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We recommend this student with consideration of membership, academic standing and not in danger of failing (C average, 70% or higher), attendance (no more than 10% absences to date) and with no major discipline problems.

Technical Instructor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High School Administrator’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Career & Technical Administrator’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Return to SkillsUSA Advisor. Advisor should bring to activity and keep in his/her possession at all times.*

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CTE School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

District 2

MEDICATION ADMINISTRATION FORM

* All medication, both prescription and non-prescription, must be kept with the SkillsUSA District 2 nurse with the exception of Epi-Pens, inhalers, and insulin.
* All medication to be administered while on a SkillsUSA sponsored trip is required to be accompanied by a medication order from the prescribing healthcare provider.
* No medication shall be administered to any student without proper completion of this SkillsUSA District 2 Medication Administration Form.
* The term “medication” includes prescription drugs as well as over-the-counter medications, vitamins, and supplements.
* Completion of the form includes signatures of both the parent/guardian and healthcare provider.
* A separate form is needed for each medication and must include the dosage, time to be administered, and any other special instructions.
* All medication must be in the original, properly labeled prescription bottle or packaging.
* Only the necessary doses of medication needed for the duration of the trip or event should be sent with the student.
* All medications should be placed in a ziploc bag clearly labeled with the student’s name and school.

PLEASE CHECK IF THE STUDENT HAS ANY OF THE HEALTH CONDITIONS LISTED BELOW:

|  |  |  |  |
| --- | --- | --- | --- |
| * Asthma | * Food Allergy (requiring medication) | * Latex Allergy | * Skin Allergy |
| * Inhaler/Nebulizer | * Hearing Problem | * Vision Problem | * Respiratory Allergy/Problem |
| * Diabetes | * Heart Condition | * Medication Allergy | * Bee/Insect String (requiring medication) |
| * Bleeding Disorder | * Seizure Disorder | * Other (please explain): | |

Please explain any of the above checked conditions, or any other special health needs/accommodations you would like the SkillsUSA Nurse to be aware of:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CTE School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

District 2

MEDICATION ADMINISTRATION FORM

**THIS FORM IS REQUIRED FOR ANY STUDENTS WHO WILL/MAY NEED MEDICATION ADMINISTERED ON THE TRIP**

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| --- |
| **TO BE COMPLETED BY THE PARENT/GUARDIAN:**  As parent/guardian of the above named student, I hereby request that the treatment described below be administered to my child and release the staff of SkillsUSA and it’s employees from liability for any damages my child may suffer as a result of the request.  Signature of Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **TO BE COMPLETED BY THE HEALTHCARE PROVIDER:**  Student’s Age:\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_  Special Considerations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date:\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| I certify that I am the healthcare provider who prescribed the treatment and that the above student is under my supervision as a patient.  Signature of Physician/Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |