Edmonds School District

Student Extracurricular Activities Contract

At least once a year, each student participant in extracurricular activities shall, as a precondition to participation, sign this contract and the Extra Curricular Informed Consent Form, covering all extracurricular activities

This Contract applies to all extracurricular activities and is in effect for up to one year.

I recognize that being a participant in student athletics or other extracurricular activities in the Edmonds School District means being a role model for other students and holding myself to a high standard of personal conduct.

In order that I may enjoy the privilege of participation in extracurricular athletics or other activities, I agree to obey and be bound by the rules of the Washington Interscholastic Activities Association, the Edmonds School District, and my school andcoaches/advisors.

I understand that the full rules for student extracurricular participation in the Edmonds School District are available to me upon request, or online at:

I understand that I may lose my privilege of participation in extracurricular activities for an entire season or longerif I possess, use, or traffic in drugs, alcohol, or tobacco; or place myself in the presence of, or remain in the vicinity of, the use of such substances prohibited by criminal law; or engage in behavior that enables others to illegally use such substances. I further understand that I may be excluded from participation if I engage in criminal acts or other serious misconduct such as harassment, bullying, hazing, fighting, or cheating.

I understand that all offenses, including first offenses, for violation of these rules may result in exclusion from participation in extracurricular activities, and that exclusion from participation may be avoided or shortened only by self-reporting, truthful cooperation and voluntary assessment and treatment.

I agree to abide by all team/activity rules, and to meet and maintain compliance with all pre-participation and academic requirements for eligibility, and I understand that I may be denied participation for failure to meet these standards.

Parent/Guardian Printed Name	Student Printed Name
Parent/Guardian Signature	Student Signature
Date	Date

Co-Curricular Music Classes/TriM
Club Name

Lynnwood High School

18218 North Road, Bothell, WA 98012
Phone: 425-431-7520

EXTRACURRICULAR INFORMED CONSENT FORM

Student Name _____ Student #_____Grade _____

Address _____ Phone _____

PARENT CONSENT

I hereby request that my son/daughter be permitted to participate in **Music Class/Tri M** during the **2018-2019** school year.

EMERGENCY INFORMATION

Parent/Guardian Name_____ Phone_____

Alternate Contact _____Phone_____

Chronic Health Problems (Asthma, Diabetes, Allergies) _____

_____

Family Doctor/Clinic _____ Phone _____

It is recommended that all students have medical or student accident insurance. Student accident insurance is available through Excel Serve. Contact the main office for details.

Health Insurance Carrier: _____ Plan#_____

I hereby authorize any medical or surgical care including anesthesia, laboratory x-rays and other procedures necessary in the emergency medical care of the above named minor during his/her activity.

PARENT/STUDENT SIGNATURES

I understand these activities are school related and agree to follow all program, building and district rules.

X Parent/Guardian Signature _____Date _____

X Student Signature _____ Date _____

This will be kept on file by the advisor and will be readily available for emergencies.

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P-103
Parent/Guardian Informed Consent for Field Trip

Student Name _____ School Lynnwood High School Date _____

General Information

The Lynnwood HS Music Dept. is planning a trip to various locations

Purpose of trip see LHS Music Department Schedule

Trip Destination Various Phone No. (_____)_____

Address Various Place of Lodging _____

We will leave from LHS at varies ❑AM ❑PM

on (date) multiple. We will return to the school on (day) varies (date) varies

at varies ❑ AM ❑ PM ❑ Itinerary is attached ❑ List of items needed is attached

Type of Transportation

☐ District Vehicle ☑ Commercial Transportation ☑ District Bus ☐ Other (explain)_____

Medical Information

The following current health problems should be noted and adequate precautions taken (please list conditions such as unusually severe reaction to bee stings, other severe allergies, diabetes, seizures, etc.): _____

_____

If your student requires medication on a field trip, a current Medication Authorization (SS-500, signed by an MD/health care provider) must be provided. These are available at the school main office or district website.

Medical insurance? ☐ *yes* ☐ *no Carrier Name* _____

If yes, includes Dental Insurance? ☐ *yes* ☐ *no*

Student Accident Insurance is recommended; low cost plans applications are available in the school offices.

*Name of Preferred Health Care Provider or Clinic:*_____ *Phone (_____)* _____

Name of Preferred Dentist or Dental Clinic: _____ *Phone (_____)* _____

This activity provides a learning experience for the students and allows them an opportunity to apply their classroom learning.

If you have questions or concerns about this activity, please contact: _____

Medical Release

In the event of an accident or illness, I understand that reasonable effort will be made to contact the parent/guardian immediately. However, if I am not available, I authorize the school district to secure emergency medical care as needed.

Although I understand that the school district will make reasonable effort to provide a safe environment, I am fully aware of the special dangers and risks inherent in participating in the activity, including physical injury and/or death. Being fully aware of the risks,

I hereby give consent for: (student) _____ to participate in the activity.

Parent/Guardian Name _____ Day Phone (_____)_____

Home Address _____ Evening Phone (_____)_____

Emergency Contact _____ Emergency Phone (_____) _____

Signature of Parent/Guardian _____ Date _____

Parent/guardian signature reflects their knowledge and approval of the activity described above. This form must be returned to school before the student is involved in the activity.

Rev 2/18

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SS-500
Authorization for Administration of Oral and Auto-Injectable Medication* at School

Student's Name _____ Birthdate _____

School _____ Grade _____

Medication is ordered to be given to a student at school only when absolutely necessary.

This Portion to be Completed by the Licensed Health Professional (LHP)
(e.g., MD, DO, ARNP, DDS, etc.)

Name of Medication	Dosage	Methods of Administration	Time of Day to be Taken

Diagnosis or reason for medication: _____

If given PRN, specify the length of time between doses and signs of when to give: _____

_____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

** Note: Auto-Injectable Medications may only be administered to students with potential for severe allergic and/or life-threatening reactions.*

I request and authorize that the above-named student be administered the above identified oral medication in accordance with the instructions indicated above from (date): _____ to (date): _____ (not to exceed current school year) as there exists a valid health reason which make administration of the medication advisable during school hours.

LHP's Signature: _____ Date: _____

LHP's Name: _____ Phone Number: (_____) _____

LHP's Address: _____ Fax Number: (_____) _____

_____

Parent/Guardian Permission

The medication is to be furnished by me in the original container, labeled by the pharmacy with the name of the medicine, amount to be taken, and the time of day to be taken. The Licensed Health Professional's name is on the label. I understand that my signature indicates my understanding that reasonable care will be exercised in administration of the medication. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the licensed health professional's directions. If medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.

Signature of Parent/Guardian: _____ Date:_____

This authorization is good for the current school year only

Note: The district endeavors to maintain consistent and safe medication storage temperature while medication is at school; this however cannot be guaranteed. The district cannot provide replacement of medication due to power failures or acts of nature.