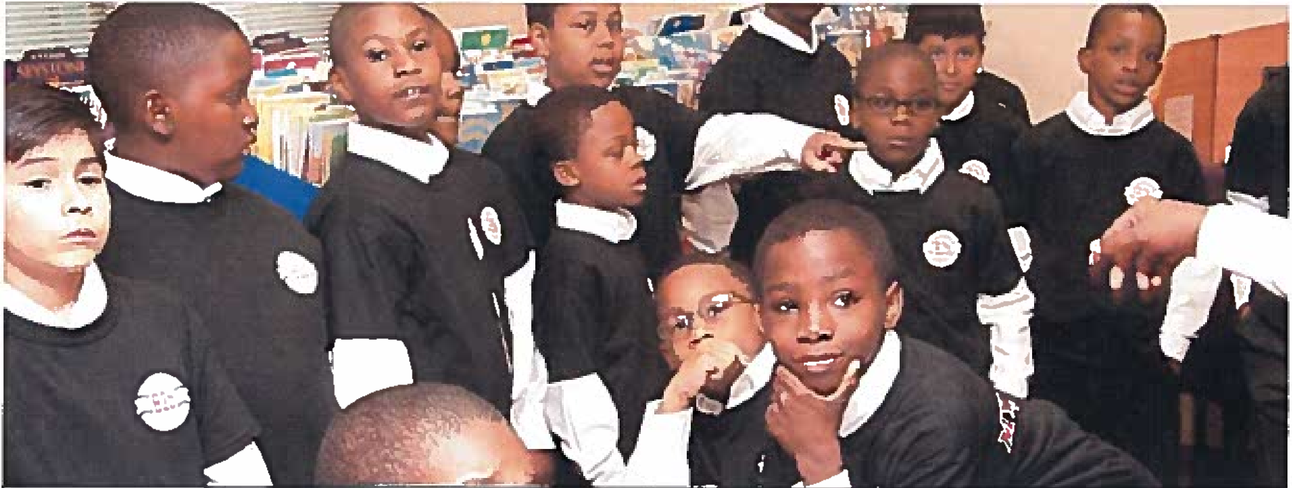

STUDENT AFFAIRS

PRESENTS

YOUNG MALES SCHOOL READINESS CAMP

JUNE 5-23, 2017

7:45 AM to 2:00 PM

EAST BROAD STREET SCHOOL

RISING 3RD, 4TH, 5TH GRADE MALES

- MATH ENHANCEMENT
- READING ENHANCEMENT
- CHARACTER DEVELOPMENT
- LIFE SKILLS

FREE!! FREE!! FREE!! FREE!! FREE!! FREE!! FREE!! FREE!!

SCCPSS

Savannah-Chatham County Public School System

Young Males School Readiness Camp 2017

For Rising 3rd, 4th, and 5th Grade Boys

STUDENT INFORMATION

Legal Last Name:	Legal First Name:	Legal Middle Name:	Suffix
Grade: (2017-2018)	Birth Date:	Age:	Student ID/FTE Number:
Student's Shirt Size:			
Home Address: (Street Address & Apartment No.)	City:	State:	Zip Code:
Mailing Address: (If different from above)	City:	State:	Zip Code:

Race/Ethnicity:
☐ Black ☐ White ☐ Hispanic or Latino ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Multi-racial ☐ Other: ______

STUDENT HISTORY

Attended SCCPSS before: ☐ Yes ☐ No	Last school attend in SCCPSS:	Previous school attended (If not SCCPSS):
Last school year attended:	Last grade attended:	Has the student ever been retained? ☐ No ☐ Yes (Please enter grade of retention):
Does student have an IEP? ☐ Yes ☐ No	Has student been in ELL/ESOL Program? ☐ Yes ☐ No	Which area is your child's greatest strength? (Please check one.) ☐ Math ☐ Reading ☐ Social Skills

PARENT/LEGAL GUARDIAN INFORMATION

Student lives with: (If other than parent, legal documentation is required.)
☐ Mother ☐ Father ☐ Both parents ☐ Legal Guardian ☐ Foster Parent ☐ Other (Specify relationship):

Parent/Legal Guardian Registering student: ☐ Mother ☐ Father ☐ Guardian ☐ Other	Last Name:	First Name:
Address: (If different from student's)		E-mail Address:
Home Phone:	Work Phone:	Cell phone or pager:
Marital Status:	Speaks English: ☐ Yes ☐ No	

OTHER PERSONS ALLOWED TO CHECK STUDENT IN OR OUT OF CAMP

****Must have state issued photo identification*

First & Last Names:	Phone Number:	Relationship to Student:
First & Last Names:	Phone Number:	Relationship to Student:
First & Last Names:	Phone Number:	Relationship to Student:

Parent's Printed Name:	Parent's Signature:	Date:

*SCCPSS- Savannah Chatham County Public School System *IEP- Individualized Education Plan *ELL-English Language Learners *ESOL-English Speakers of Other Languages

Authorization to Give Medication at School

If medication can be given at home or after camp hours, please do so. However, if medication must be given during camp hours this form must be completed.

Student's Name: ____________________ **DOB:** ______________ **Age:** ____________
Program: Young Males School Readiness Camp **Site:** ______________________________

Permission is hereby granted to the school principal or designee to administer/supervise in medication administration to my child according to the instructions of the statements below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medication will be taken directly to the office/clinic by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

I hereby release and discharge the Savannah-Chatham County Public School System and its employees and officials, from any liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication, and I hereby release said aforementioned officials from any liability because of any injury or damage which might occur.

I give the staff of the above mentioned program permission to contact my child's health care provider to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

Name of medication: ____

Dose:__________ **Route (by mouth, topical, etc)** __________ **Amount:** __________

Time(s) to be given: __________**Stop Medication On:** __________ **Quantity of medication:** ______

Condition/Illness Requiring Medication: ________________________________

Possible Side Effects: ________________ **Allergies:** ________________________

Healthcare Provider's Name: ________________________ **Phone:** ______________

Received by: ______________________ **Date:** ______

All medications will be destroyed at the end of each school term if not picked up by parent. Please initial _____

I hereby authorize the personnel, employees, and officials of Savannah-Chatham County Public Schools to assist my child in taking prescribed medication.

______________________________ ______________
Parent/ Legal Guardian Signature **Date**

Home Phone: __________ **Work Phone:** __________ **Pager/Cell Phone:** __________

Written Authorization for Self-Administration of Asthma Medication and/or Epi-Pen by student and/or minor at school

Student Name: ______________________________

Date of Birth: ____________________ **Grade:** ____________________

I, ______________________________, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of asthma medication or Epi-Pen by this student while in school, at a school sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school operated property. The student demonstrates full understanding of the proper use of his/her asthma medication.

I understand that:

- the school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his or her asthma medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty asthma medication and asthma devices
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with asthma medication
- the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of asthma medication and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff

I take sole responsibility for:

- the monitoring of asthma medication, medication use, and refilling of prescriptions for asthma medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered asthma medication
- ensuring the student always carries his/her asthma medication on his/her person
- deciding if back-up medication will be kept at the school and providing the school with the back-up medication
- informing school staff in writing of any changes in the student's treatment or asthma management
- informing the school of any asthma exacerbations, hospital visits, and/or new or changed student medical information
- informing school staff in writing of any medication side effects that warrant communication to the parent/guardian
- coordinating distribution of the student's asthma management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff)

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above named student. I release the SCCPSS School System and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of his or her asthma medication.

______________________________ ____________

Parent/Legal Guardian Signature Date

I, ______________________________, the above-named student have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

______________________________ ____________

Student's Signature Date

The above named student has been instructed and demonstrates understanding of the proper use of his/her asthma medication. It is my professional opinion that the student be permitted to carry and self-administer his/her asthma medication. I have provided the parent/guardian with a written asthma emergency/management plan including the name, purpose, dosage, and administration directions of the asthma medication.

______________________________ ____________

Physician's Signature Date

EMERGENCY TRANSPORTATION/ TREATMENT RELEASE

Student's Legal Name

Last:___________________________________

First:___________________________________ **Middle Initial:**______________

In the event that I cannot be reached in an emergency situation, I give permission for this student to be transported

(Please check one)

☐ to the closest local hospital
☐ to a specific hospital (Please specify): ______________________

and authorize the hospital to provide emergency medical or surgical treatment. I will assume full responsibility for all charges related to the above, and release the hospital, the school, Savannah-Chatham County Public School System, its agents, employees, administrators, and assigns from any and all liability, claims and causes of action arising in connection with the transportation and/ or treatment of the student named hereon.

Current health insurance information:

Company____________________________ ID Number ____________________

____ __________________
Parent/ Legal Guardian's Signature Phone

____
Date