LAND FOR LEARNING

NATURE CAMP, 2024

May 6th-8th or May 8th-10th

Melissa Burger, Kacie Bruncic, Breann Spohr,
Tony Hanson, Kenlea Meeker,
Marguerite Rousseau, Jessica Wright,
Rebekah O'Donnell, Jana Vasquez

Land for Learning

Dear Parents:

Although our 6th grade field trip is not until May, it's already time to start preparing for this awesome event. WE wish to thank you in advance for all your support and assistance as we collect the required finances and paperwork. On the following pages you will find information dealing with the Land for Learning field trip.

$50 Deposit due February 15th, 2024 (you may choose to pay in full)

All forms must be returned to school by March 15th, 2024 to your child's Lit/Skills teacher.

1. **Special Power of Attorney (MUST be notarized).**
2. **Medication Permission Form**
3. **Acknowledgment and Assumption of Personal Responsibility**
4. **Health Services/School Medication Authorization Form** (if applicable) **(including over the counter medication a student may bring that is not listed on the Medication Permission form and prescription medications)**
5. **Asthma Administration Form** (if applicable)

TOTAL COST OF STUDENT TRIP IS $240- Due March 15th

Fulton is scheduled to attend:
Group 1- May 6th (leave 9am) – May 8th (return by 2pm)
Group 2- May 8th (leave 9am)- May 10th (return by 2pm)

O'FALLON COMMUNITY CONSOLIDATED SCHOOL DISTRICT NO. 90
O'Fallon, Illinois 62269
SPECIAL POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT, that I, _____, residing at _____, desiring to execute a **Special Power of Attorney** have made, constituted and appointed, and by these presents do make, constitute and appoint, jointly and severally:

(Name)	(Address)
Shanna McHellen	O'Fallon School District 90, O'Fallon, IL
Melissa Burger	O'Fallon School District 90, O'Fallon, IL
Tony Hanson	O'Fallon School District 90, O'Fallon, IL
Breann Spohr	O'Fallon School District 90, O'Fallon, IL
Kenlea Meeker- Cobb	O'Fallon School District 90, O'Fallon, IL
Kacie Bruncic	O'Fallon School District 90, O'Fallon, IL
Jana Vasquez	O'Fallon School District 90, O'Fallon, IL

My attorney-in-fact to act as follows, giving and granting unto my said attorney full power to authorize and execute for any and all medical and hospital care treatment, including major surgery deemed immediate and necessary by a duly licensed physician selected by my attorney-in-fact for the health and well-being of my following named child: _____

Further, past medical history reveals that the above named minor child may be treated with medications previously authorized during the school current school year or those listed on the Medication Permission Form.

Any known serious medical condition(s), allergy(s), or other factor(s) concerning the above named child are listed (if none, state none): _____

Further, I do authorize my said attorney-in-fact to perform all necessary acts in the execution of the aforesaid authorization with the same validity as I could effect if personally present. Any act or thing lawfully done hereunder by my said attorney shall be binding on myself and my heirs, legal and personal representatives, and assigns. This **Special Power-of-Attorney** shall be effective for May 6th- 10th 2024 unless otherwise revoked or terminated by me.

In Witness Whereof, I have hereunto set my hand this _____ day of _____, 2024.

_____
Signature of Parent or Guardian

STATE OF: _____

COUNTY OF:_____ CITY OF:_____

I, _____, a notary public in and for the county (city) and state aforesaid, do hereby certify that on the _____day of_____, 2024, before me personally appeared, who is known by me to be the identical person who is described in, whose name is subscribed to, and who is signed and executed the foregoing instrument, and having first made known to her/him the contents thereof, she/he personally acknowledged to me that she/he signed and sealed the same on the date it bears as her/his true, free and voluntary act and deed for the uses, purposes, and consideration therein set forth.

IN WITNESS WHEREOF, I here unto set my hand and official seal this day and year above written.

_____
Notary Public

District 90 L4L MEDICATION PERMISSION FORM

Illinois law allows for medication to be administered during school-related activities if certain criteria are met. We will be taking the following medications in case they are needed. In order to give these medications to your child, we will need a signed permission slip indicating the specific item(s) he/she can take. Any medications not checked either yes or no **will be considered a no.** Medications will be administered per package directions.

Please note: The staff will attempt to notify you prior to administering any medications listed below that you have indicated your child may take.

YES	NO		YES	NO	
____	____	Tums	____	____	Sting Kill Wipes (bug bites)
____	____	Imodium AD (adult 2mg)	____	____	Solarcaine (for sunburns)
____	____	Tylenol Caplets (325mg)	____	____	Cortisone Cream
____	____	Ibuprofen tablets (200mg)	____	____	Neosporin
____	____	Benadryl (1 tablet)	____	____	Calamine lotion
____	____	Dramamine			

If your child requires medication in liquid or chewable form, then you **MUST** supply the medication along with a signed **DOCTOR'S NOTE**.

Any medication not listed above (including ALL over-the counter medications, or those not currently authorized at school, will require an OVERNIGHT MEDICATION AUTHORIZATION FORM from your physician

My child will be taking the following over-the-counter medications (**with an Overnight medication form turned in to the nurse**) not listed in the above stock meds:

_____

_____

This form must be completed and returned in order for the medications to be administered during Land for Learning. **(No medications, other than an inhaler/epi pen, will be kept with the student or the student's bags)**

Parent-provided medications will need to be sent in appropriately labeled containers (not in bags). Daily medication will ***NOT*** be sent from the school supply

We are looking forward to spending this week with your child. Thank you for your help in making this trip a memorable experience for all of us.

_____ has my permission to take the above medications if needed.

Parent signature_____ Date_____

O'FALLON Community Consolidated School District 90

OVERNIGHT FIELD TRIP

Confidential Medical History/Permission to Treat Form

Part 1: (to be completed by parent or legal guardian)

Student Name:_____ Birthdate_____Sex:____Age:_____

Part 2: Medical History (to be completed by parent or legal guardian)

If the student has had any of the following conditions or is currently experiencing them, please put a check next to the number and give details at the end of the section. If you have any questions about these statements, ask your physician.

____ 1. Allergy to foods, materials, medicines, etc.
____ 2. Dizzy spells, fainting, convulsions, or persistent headaches
____ 3. Frequent infection of the throat, tonsils, sinuses, or ears
____ 4. Chronic cough, bronchitis, bloody sputum
____ 5. Shortness of breath, or asthma on exertion
____ 6. Chest pains on exertion or deep breathing
____ 7. Low or high blood pressure
____ 8. Frequent abdominal cramps, sever menstrual cramps
____ 9. Hernia
____ 10. Joint pain, swelling or stiffness without injury
____ 11. Chronic skin problem (rash-infection)
____ 12. Reaction to extremes of temperature, frostbite
____ 13. History of diabetes, thyroid trouble, bleeding problems
____ 14. Blood born virus/diseases (i.e. HIV, hepatitis)
____ 15. Palpitation of the heart, irregular heartbeat, heart murmurs or poor circulation
____ 16. Frequent nausea or vomiting, food intolerances, heart burn
____ 17. Special dietary requirements, i.e. vegetarian, other special food restrictions
____ 18. History of serious injuries, hospitalizations or operations

Details:_____

PRESCRIPTION MEDICATION

(Medications will be distributed in accordance with existing O'Fallon School District 90 Policy)

If the child will need any prescription medications, please send it in appropriately labeled containers. Daily medications will NOT be sent from the school supply.

Students will require a completed Medication Authorization Form for any prescription medication that is not currently being given at school.

Does the student have an allergy to bee stings, insect bites, poison ivy, or food that will require medication? If yes, please specify:_____

IMMUNIZATION HISTORY

All immunization records are up to date and on file at _____

PARENT AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all activities, except as noted by the parent. I hereby give permission to share medical information with medical personnel, School District 90 staff, and non-school personnel associated with this program. In the event I cannot be reached in an **EMERGENCY**, I hereby give permission to the physician selected by the Program Director to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for my child as named above

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

Health Services

O'Fallon School District 90

SCHOOL MEDICATION AUTHORIZATION FORM: OVERNIGHT FIELD TRIP

Any student who is to take medication not previously authorized during an overnight school-related activity may be assisted by the school nurse or other designated school personnel if the school district has received the following: (1) a written statement from a licensed health care provider, with prescriptive authority, working within the scope of their practice, detailing the method, amount and time the medication is to be taken, (2) a written statement from the parent/guardian requesting the school district to assist the pupil in the manner set forth by the physician statement and (3) the medication shall be in a properly labeled pharmacy bottle or original container.

All medication must be kept and dispensed by a District 90 employee.

Physician Statement

_____ is under my professional care and is on the following
(Student Name)

Medication: _____ Dosage: _____

Method of Administration: _____ Time Schedule: _____

Side Effects of particular concern: _____

Start Date: _____ Discontinue Date: _____

Diagnosis: _____

I recommend that the school nurse or other designated school personnel assist in the administering of the medication during this school-related activity.

_____

Physician Signature **Print Name, Address and Phone Number** **Date**

If HealthCare Provider is APN or PA, name of Collaborating/Supervising Physician: _____

****

Parent or Guardian Statement

As the parent/guardian of the above named student, I request the O'Fallon School District 90 to assist in carrying out the physician's instructions in the administration of the above named medication during the school-related activity. I further agree that when the medication is so administered, I waive any claims I might have against the school district, its employees and agents arising out of administration of said medication. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication. ***I have read the policy and procedures for administration of medication in O'Fallon School District 90 and agree to abide by them.***

_____

Parent signature **Print Name** **Date**

_____

Address **City** **Phone** **Gr/Teacher**

Please return this form to the school signed by the licensed health care provider, working within their scope of practice, and the parent/ guardian.

NO MEDICATION (PRESCRIPTION OR OVER THE COUNTER) NOT PREVIOUSLY AUTHORIZED WILL BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES.

Carriel Junior High School	fax (618) 622-2940	EK Elementary School	fax (618) 632-7580
Evans Elementary School	fax (618) 632-1530	Fulton Junior High School	fax (618) 624-9390
Hinchcliffe Elementary School	fax (618) 632-1774	Marie Schaefer School	fax (618) 632-9258

Moye Elementary School fax (618) 206-2260

ACKNOWLEDGMENT AND ASSUMPTION OF PERSONAL RESPONSIBILITY
And
PHOTO RELEASE AUTHORIZATION
Land for Learning Institute, Inc.

I understand that during my participation in this Land for Learning Institute (LFLI) program or activity, including but not limited to canoeing, hiking, and team building, I may be exposed to psychologically and physically stressful and challenging situations.

I understand also that, although the Land for Learning Institute has taken precautions to provide proper organization, supervision, instruction and equipment for each program and activity, it is impossible for LFLI to guarantee absolute safety. Further, I understand that I share responsibility for safety during each program or activity, and I assume that responsibility.

I waive any claim which may arise against the Board of Directors of the Land for Learning Institute and/or its employees as a result of my participation in the Land for Learning Institute program or activity, including those which are the direct result of the negligence of the Board of Directors and/or its employees.

I have accepted the responsibility for verifying my personal health and medical history and that I have no physical or psychological problems that would prohibit or shorten my participation in a Land for Learning Institute program or activity.

I agree to comply with the instructions and directions of the Land for Learning Institute staff members during the program or activity. If at any time during this program the LFLI staff determines my behavior to be detrimental to the mental or physical health of myself or LFLI participants, staff, equipment or contractual vendors, I realize LFLI reserves the right to immediately remove me from the program.

I also provide my consent and photo release authorization to the Land for Learning Institute for the use of any photos or video that may be taken of me during this program for promotional purposes only.

I also realize if my child is removed from this program for medical reasons or behavior detrimental to the program, as outlined above, I will make immediate arrangements for and incur all costs related to his/her safe transport back to my guardianship.

_____ _____

Participant's Signature or Participant's Name if a minor Date

_____ _____

Signature of Parent or Guardian Date

O'FALLON Community Consolidated School District 90

COMPLETE THIS FORM IF YOUR CHILD IS BRINGING AN INHALER/EPI PEN WITH HIM/HER ON THE TRIP

Health Services

Asthma/Allergy Administration: Parent Release Form

Student Name: _____ Date of Birth: _____

School Name: _____ Grade/Teacher: _____

Parent/Guardian Name: _____

Parent/Guardian Phone #: _____

Emergency Contact: _____ **Emergency Phone #:** _____

Health Care Provider Name: _____ Health Care Provider Phone #: _____

I authorize the School District and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30). _____ *Parent/Guardian initials*

**YOU MUST PROVIDE THE PRESCRIPTION LABEL! OTHERWISE, WE WILL NEED THE MEDICATION AUTHORIZATION FORM COMPLETED BY THE DOCTOR.

Parent Statement

As the parent of the above named student, I request that my student be allowed to carry and self-administer asthma rescue medication/allergy epi-pen in school, at any school-sponsored activity, when under the supervision of school personnel, or before or after normal school activities, such as while in before-school or after-school care on school-operated property. I further agree that when the medication is so administered, I waive any claims I might have against the school district, its employees and agents arising out of administration of said medication. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication. ***I have read the policy and procedures for administration of medication in O'Fallon School District 90 and agree to abide by them.***

_____

Parent Signature Print Name Date

HELP WANTED!

Land for Learning

If you are interested in making memories with your child and you enjoy the outdoors, Land for Learning is a great trip to chaperone. If you would like to secure your spot, you must complete the following requirements by **April 15th, 2024**

1. **Submit the $100 payment-**
2. **Complete a background check** (This is an additional cost)
   **** This needs to be done as soon as possible as it is time sensitive and takes a few weeks to process.**

3. **Complete the Volunteer Training on line.**
   a. **Visit district webpage www.of90.net**
   b. **Under Parents/Students tab locate Volunteer Training Presentation**
   c. **Print out Certificate when finished and bring to the office, this is a must for completion of training.**
   d. **Contact Dr. Herrell if you have any issues or concerns.**

For our planning purposes please fill out the bottom portion of this form and return to Ms. Burger by **March 17th, 2024.**
If you are interested in attending as a chaperone, please provide the following information:

Chaperone's Name:_____

Student's Name:_____

Phone #_____

Email Address:_____

- Contact Miss Burger with any questions or concerns about chaperoning this trip. She can best be reached at mburger@of90.net. Once we have chaperones selected she will be sending out emails with important updated information. The sooner the better when completing the steps to chaperone, this is extremely helpful for our planning purposes.