

Parental Consent to CCSD Health Care Chaperone

Child's Name _____

School: Wando HS Teacher/Trip Sponsor: Lambert, Handel, Radecke

Destination: multiple trips

Departure date/time: _____

Return date/time: _____

Medications on this field trip will be administered by Chaperone

This person is a _____ CCSD Employee OR licensed medical professional.

To be eligible to serve as a CCSD health care chaperone, an individual must:

- Be a CCSD employee or a licensed medical professional
- Be willing to provide medications and emergency treatments, and willing to sign a confidentiality agreement.
- Acknowledge that their primary responsibility is to meet the health care needs of one or more specific participating students.
- Participate in a training provided by the school nurse.
- Follow the CCSD Medication policy JLCD and the accompanying regulations.
- Pass a criminal background check

Parental Consent Given To CCSD Health Care Chaperone

I (parent/legal guardian) _____ give my consent for the Health Care Chaperone named above
(printed name)

to provide my child _____ with all medications and emergency treatments.
(printed name)

Signature of Parent/Guardian

Date