RAYMOND SCHOOL DISTRICT

ADMINISTRATION OF OVER THE COUNTER (NON-PRESCRIBED) MEDICATION

Any pupil who needs to take an over the counter medication during the day shall be assisted by the school nurse or another member of the school staff so designated by the school principal. The School District must also have received, and have filed with the student health record, a written authorization (request) from the parent/guardian of the pupil indicating the desire that the school assist the pupil in taking the medication.

Note: An over the counter medication is a medication that can be purchased without a doctor's prescription. Examples of such medications are Zyrtec, Tylenol, or Benadryl.

Parent/Guardian Authorization

I hereby request and give my permission for a designated member of the school staff to assist my child

_____ in taking the over the counter (OTC) medication

_____.
(Name of OTC medication)

Please list any and all other prescriptions and/or over the counter medications and/or supplements that your child takes daily:

_____
_____

Please list all medical conditions that your child's doctor has diagnosed him/her with:

_____

Parent/Guardian Authorization

I hereby give my permission to have the school nurse or designated staff member administer the above listed medication and/or the principal or his/her designee assist the student with the taking of his/her medication.

Parent/Guardian Name_____

Parent/Guardian Signature_____

Phone_____ Date_____

SAU 6/13/2018 JH

RAYMOND SCHOOL DISTRICT

PRESCRIPTION MEDICATION DURING SCHOOL DAY

(a) Any pupil who is required to take during the school day a medication prescribed by a licensed physician, advanced registered nurse practitioner, or licensed physician's assistance, shall be supervised in taking medication by the school nurse, who shall be responsible for administering the medication.

(b) If the school nurse is not available, the following option shall apply in implementing the above:
The building principal or designee may assist students in taking required medications by making such medications available to the student as needed; and by observing the student as he/she takes or does not take his/her medication.

PHYSICIAN'S STATEMENT

_____ is taking _____
(student's name) (medication/dosage/route)

For _____. Please administer at _____ for _____
(diagnosis) (time) (# of days)

Additional Information_____

Physician Name_____ Physician Signature_____

Address_____Phone_____

Date_____

PARENT OR GUARDIAN AUTHORIZATION

I hereby give my permission to have the school nurse administer the above listed medication and/or the principal or his/her designee assist the student with the taking of his/her medication.

Please list all other medications and/or medical conditions:

Parent/Guardian Name_____

Parent/Guardian Signature_____

Phone_____ Date_____

SAU 6/11/2018 JH

RAYMOND SCHOOL DISTRICT SAU 33
INCIDENT COMPLAINT AND REPORTING FORM*
(FOR HARASSMENT OR BULLYING)

1. **Name of Person Reporting Incident(s):** _____

2. **Check whether you are the:** ☐ Victim/target of behavior ☐ Reporter (not victim or target) (or his/her parent/guardian)

3. **Check whether you are a:** ☐ Student ☐ Staff member (specify) _____
☐ Parent/Guardian ☐ Other (specify) _____

3A. **Provide Tel. No.; E-mail address:** _____

4. **If student, state school name:** _____ **Grade:** _____

5. **If staff member, state school name or work site:** _____

6. **Information about the Incident:**

Check whether:

A. **Name of victim/target of behavior:** _____ ☐ Student ☐ Employee ☐ Other
Others: _____ ☐ Student ☐ Employee ☐ Other

B. **Name of Subject** (person who engaged in behavior): _____ ☐ Student ☐ Employee ☐ Other
Others: _____ ☐ Student ☐ Employee ☐ Other

C. **Date and time of incident:** _____

D. **Location:** ☐ class ☐ hall ☐ cafeteria ☐ other area inside school ☐ school grounds ☐ bus ☐ other

E. **Nature of incident** (check all that apply): ☐ physical ☐ verbal ☐ gesture ☐ electronic ☐ written ☐ personal property ☐ school property ☐ other

F. **Are you aware of similar or related incidents?** ☐ Yes ☐ No

7. **Witnesses** (who saw incident or has information about how or why incident occurred) (Use additional paper, as needed)

Name: _____ ☐ Student ☐ Employee ☐ Other _____
Name: _____ ☐ Student ☐ Employee ☐ Other _____
Name: _____ ☐ Student ☐ Employee ☐ Other _____

8. **Describe the details of the incident, in the order it happened, and specifying where it occurred. Identify what each person involved did and said, stating actual words used. Use additional paper as needed.**

9. **Give any background information that may help explain how or why incident occurred.**

10. **Signature of Complainant or Reporter:** _____ **Date:** _____

11. **Form Provided to:** _____ **Position:** _____ **Date:** _____

BULLYING/HARASSMENT INVESTIGATION DETERMINATION APPEAL

As per Raymond School District Policy JICDA
Student Safety and Violence Prevention - Bullying and Cyberbullying
Section XV, Appeal

Please complete this form and submit to the Superintendent's Office.

Student Name: _____

Incident Date: _____ Student Grade: _____

Parent/Guardian Name(s): _____

Parent/Guardian Contact Information:

Address _____

Phone (H) _____

Phone (C) _____

Email _____

Please state the reason(s) why you are aggrieved.
(How/why is the decision incorrect and/or how does it adversely impact your child?)

_____
_____
_____
_____
_____
_____
_____

What is the nature of relief you seek?
(What do you want the District to do to address the situation?)

_____
_____
_____
_____
_____
_____
_____

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

RAYMOND SCHOOL DISTRICT
BUS STOP CHANGE REQUEST

Parent Name:_____

Street Address:_____

Telephone Number:_____ Child's Name:_____

Child's Grade:_____ Bus Number:_____

Current Bus Stop:_____ Requested Bus Stop:_____

Walking Distance to Current Stop:_____ Walking Distance to Requested Stop:_____

Reason/s for Request:_____

_____

_____

_____

Parent/Guardian Signature:_____ Date:_____

FOR OFFICE USE ONLY:

Date of Review:_____

Road Width:_____ Shoulder Width:_____

Sight Distance from Requested Stop: North_____Ft. South_____Ft.
East_____Ft. West_____Ft.

Sight Distance from Current Stop:_____
Walking Distance to Current Stop:_____
Walking Distance to Requested Stop:_____

ALL DISTANCES APPROXIMATE

Additional Information:_____

_____

Accepted by Transportation Committee 1/7/98