
PLEASE CHECK IN BEFORE
OUR MEETING BEGINS

Trip Code: 322/HAP/CLE
Group ID: 233145

Glory of the Habsburgs

March 22nd – 31st, 2019

2. Cleveland - Philadelphia (CLE-PHL)

Domestic flight AA4927 by American Airlines serves route within United States (CLE to PHL). The flight departs Cleveland, Cleveland-Hopkins on February 13 10:58 (10:58 am) and arrives Philadelphia terminal «F» on February 13 12:23 (12:23 pm). Flight duration is 1h 25m.

AA 4927

American Airlines

Departure	Arrival
10:58 / 10:58 am	12:23 / 12:23 pm
February 13, Wednesday	February 13, Wednesday
	Terminal F
Cleveland-Hopkins (CLE)	**Philadelphia (PHL)**
Cleveland, United States	United States

Flight duration: 1h 25m

Embraer ERJ 145

AA4927 status

FORMS

All forms are due on 2/25/19 To Ms. Gardner or Ms. Stone

HEALTH ALERT ☐

EMERGENCY MEDICAL AUTHORIZATION

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. This information may be shared with the educational team to best meet your child's needs.

Student Name _____ Phone # _____ Bus # _____
Address _____ School District _____
_____ School Attending _____
Address Change Y N Birth Date _____ Sex M F Grade _____ Home Room _____

Residential Parent or Guardian: **Email: _____
Mother _____ Day Ph # _____ Cell # _____
Father _____ Day Ph # _____ Cell # _____
Other Contact _____ Relationship _____ Ph # _____
Other Contact _____ Relationship _____ Ph # _____

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone # _____
Dentist _____ Phone # _____
Medical Specialist _____ Phone # _____
Hospital _____ Phone # _____

Check below any *CURRENT* health condition that may require attention during the school day:

☐ Allergies (be specific)
- ☐ Food _____ **EpiPen** ___Yes ___No
- ☐ Medicine _____
- ☐ Bee sting **EpiPen** ___Yes ___No
- ☐ Other _____

☐ Asthma **Uses emergency inhaler** ___Yes ___No
Inhaler will be at school ___Yes ___No

☐ Cancer
☐ Diabetes
☐ Seizures
☐ Heart problems (be specific) _____
☐ Physical disability (be specific) _____

☐ Other health conditions (be specific) _____
☐ Previous surgeries (include date) _____
☐ Previous concussion/head injury – year _____
☐ Hearing problems Has hearing aids ___Yes ___No
☐ Vision problems (be specific) _____
Wears: ☐ Glasses ☐ Contacts
☐ ADHD
☐ Behavior/emotional problems _____
☐ Bleeding Disorder
☐ **NO CURRENT HEALTH CONDITIONS**

☐ **List all medications and dosages your child receives on a continual basis:** _____

PLEASE COMPLETE PART I *OR* PART II – NOT BOTH

Part I – TO GRANT CONSENT
In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the designated physician or dentists, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date_____ **Parent or Guardian Signature**_____

Part II – REFUSAL TO CONSENT
I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: _____

Date_____ Parent or Guardian **REFUSAL** Signature_____

YOU ARE RESPONSIBLE FOR KEEPING YOUR OWN PASSPORT AT ALL TIMES

Jackson Local Schools
Medical Consent, Release and Assumption of Risk
(International Travel)

Participant's Name: _____

As used herein: JACKSON LOCAL SCHOOLS shall include officers, directors, employees, staff, and designated chaperones "UNDERSIGNED" shall be the father and/or mother, or the guardian of PARTICIPANT, or the PARTICIPANT if eighteen years of age or older.

The UNDERSIGNED understand that during the field trip under the direction of JACKSON LOCAL SCHOOLS, certain risks and dangers may occur, including, but not limited to, hazards, accidents or illness of any kind whether foreseeable or unforeseeable, the forces of nature, and travel by airplane, automobile, bus, train, or other conveyance. The UNDERSIGNED understand that many activities associated with the field trip and related activities may take place in remote places without medical facilities.

The consideration of the right to participate in the field trip and related activities and to utilize the services, including food, as provided, the UNDERSIGNED hereby assume all risks, including those set forth above, and hereby hold JACKSON LOCAL SCHOOLS harmless from any and all liability, actions, causes of actions, debts, claims, and demands of every kind and nature whatsoever whether foreseeable or unforeseeable, which arise from or in connection with the above described field trip and related activities. This release and assumption of risk shall apply to the negligent acts or omissions of JACKSON LOCAL SCHOOLS. The terms hereof shall serve as a release and assumption of risk for the UNDERSIGNED, his or her heirs, executors, administrators, and members of the UNDERSIGNED's family.

In the event emergency medical treatment is required for the PARTICIPANT, while PARTICIPANT is under the control and direction of JACKSON LOCAL SCHOOLS, and if consent is requisite to any such treatment for the PARTICIPANT on behalf of the UNDERSIGNED, said consent may be granted or withheld by JACKSON LOCAL SCHOOLS as each of them, in their sole direction, shall determine. The UNDERSIGNED hereby waive any and all claims, which they may have against JACKSON LOCAL SCHOOLS arising from the granting or the withholding of the aforesaid consent.

In the event that emergency medical treatment is provided to the PARTICIPANT, the UNDERSIGNED hereby authorize JACKSON LOCAL SCHOOLS, and/or any other entity providing medical services or material in conjunction with emergency medical treatment, to seek payment for said services or material and assigns any medical, insurance benefit for the same services or material to JACKSON LOCAL SCHOOLS from the following insurers of the PARTICIPANT:

_____ _____
INSURER NAME POLICY NUMBER

The UNDERSIGNED hereby guarantee payment of any medical insurance deductible, any service not covered by PARTICIPANT's insurer, or any other cost incurred in providing emergency medical treatment, to JACKSON LOCAL SCHOOLS, and/or any other entity providing or paying for medical services or material in conjunction with emergency medical treatment.

The UNDERSIGNED below have read the Medical Consent, Release and Assumption of Risk and hereby voluntarily agree to the same, and have answered all questions on the Medical History Form (reverse side), to the best of his or her ability:

_____ _____
STUDENT or PARTICIPANT DATE

_____ _____
PARENT(S) or GUARDIAN(S) DATE

Sworn to me and subscribed by _____ in my presence the _____ day of _____, 20_____.

_____
NOTARY

Rev. 10/14

Jackson Local Schools
Medial History Form
(International Travel)

All fields in this section *MUST* be completed.

Last Name:	Full First Name:	Middle Name:
Gender:	Birthdate (MM/DD/YY):	Body Weight:	Country of Citizenship:
Passport Number:	Passport Expiration Date (MM/DD/YY):	Student Visa Number & Expiration Date (MM/DD/YY) Green Card Number & Expiration Date (MM/DD/YY):

Student Address:		
City:	State:	Zip Code:
Daytime Phone:	Cell Phone:	Evening Phone:
School:		Current Grade/Grade Just Completed:
Parent/Guardian Name(s):		
Parent Address:		
City:	State:	Zip Code:
Daytime Phone:	Cell Phone:	Evening Phone:

MEDICAL INFORMATION

Indicate any ***CURRENT*** health conditions below (elaborate on a separate, attached sheet of paper, if necessary):

- ☐ **NO CURRENT HEALTH CONDITIONS**
- ☐ Food allergies: _____ Epi-pen ☐ yes ☐ no
- ☐ Medication allergies: _____
- ☐ Bee and/or wasp sting allergies Epi-pen ☐ yes ☐ no
- ☐ Other allergies: _____ Epi-pen ☐ yes ☐ no
- ☐ Asthma – uses emergency inhaler ☐ yes ☐ no
- ☐ Cancer
- ☐ Diabetes
- ☐ Seizures
- ☐ Bleeding disorder
- ☐ Celiac/gluten-free
- ☐ ADHD/ADD
- ☐ Hearing difficulties – has hearing aids ☐ yes ☐ no
- ☐ Vision difficulties – wears ☐ glasses ☐ contacts
- ☐ Heart problems (be specific): _____
- ☐ Physical disabilities (be specific): _____
- ☐ Previous concussion/head injury (year): _____
- ☐ Behavior/emotional issues: _____
- ☐ Other health conditions (be specific): _____

List any *current* medications (**all medications** must be in their original containers): _____

_____

Have you had any surgeries in the past year? _____ If so, please describe: _____

Date of last tetanus shot/booster (TDaP): _____ Date of last dental exam: _____

Are you a vegetarian? _____ List any dietary restrictions: _____

Do you have any physical impairments/restrictions that might your ability to participate in this program? _____ If yes, please explain: _____

Indicate other special considerations that we should be aware of: _____

_____

In the event of either illness or an accident, we will attempt to contact the parent/guardian and/or family health practitioner.

Health Care Provider Name:		Phone:
Emergency Contact:	Relationship:	Phone:

IMPORTANT: THIS FORM MUST BE COMPLETED, NOTARTIZED, AND RETURNED TO THE TRIP COORDINATOR BY THE SCHEDULED DUE DATE!

Rev. 10/14

Jackson Local Schools
School Medication Administration Authorization

Student's Name:_____ DOB:_____

Grade:_____ Building:_____ Teacher:_____ School Year:_____

Medication Allergies/Interactions:_____

This form must be completed fully, in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of medication administration.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original packaging with the label intact and contain the student's name.
- A parent/guardian **must** bring the medication to school. Students **are not** permitted to bring medication to school.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or child's medication.

♦PRESCRIBER'S AUTHORIZATION♦
(this section must be completed by the prescriber)

Condition for which medication is being administered:_____

Medication:_____ Strength:_____ Dose:_____

Amount:_____ Route: _____ Time:_____ If PRN, frequency:_____

If PRN, for what symptoms:_____

Relevant side effects: □ None expected □ Specify:_____

Medication administration begin date:_____ Medication administration end date:_____
**Note: orders are only valid for one school year*

Prescriber's Name/Title:_____

Telephone:_____ Fax:_____

Address:_____

_____

Prescriber's Signature:_____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

Date:_____

A verbal order was taken by the school nurse, _____ (name) for the above medication on _____ (date)

♦PARENT/GUARDIAN AUTHORIZATION♦

I/We authorize designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that the medication must be in the ***original*** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate. I/We understand that at the end of the school year, an adult must pick up the medication; otherwise it will be properly discarded. I/We authorize the school nurse to communicate with the health care provider/prescriber or pharmacist to clarify the above listed medication order as allowed by HIPAA.

Parent/Guardian Signature: _____ Date:_____

Contact Phone #1:_____ Contact Phone #2:_____

Order reviewed by the school nurse: _____ Signature _____ Date

Rev: 03/13

Jackson Local Schools
Certification of Authorization for Administration of Over-the-Counter Medication
Field Trip Form

♦DEMOGRAPHIC INFORMATION♦

Student Last Name:	Student First Name:	Student Middle Name:
Street Address:	City:	Zip Code:
School:	Grade:	Birth Date:
Emergency Telephone Number(s):		

Does this student have any allergies to foods or medications? □ yes □ no

If so, please list: _____

♦OVER-THE-COUNTER MEDICATION♦

The Jackson Local Schools staff members accompanying students on the trip will have the following medications available. Please review the list and **INITIAL** next to the medication that you consent to be administered to your child.

Parent Initial	Medication	Parent Initial	Medication
	Acetaminophen (ex. Tylenol)		Ibuprofen (ex. Advil, Motrin)
	Cough Medication (ex. Robitussin)		Decongestant (ex. Sudafed/Mucinex)
	Antihistamine (ex. Benadryl/Claritin)		Motion Sickness Medication (ex. Bonine)
	Antidiarrheal (ex. Imodium)		Antacids (ex. Tums, Maalox, Mylanta)
	Antibacterial Ointment (ex. Neosporin)		Topical Corticosteroid (ex. Hydrocortisone Cream)
	Cough drops/Throat lozenges		
	If there are other OTC medications that your child might need, please **list them below** and initial the box.(Note: Parent is responsible for providing medication indicated)		

♦PARENT/GUARDIAN AUTHORIZATION♦

Authorization to administer the above listed over-the-counter medication lasts for the duration of the trip only.

With full knowledge of emergencies, dangers, and risks related to the administration of such medication by Jackson Local Schools' district employees, officers, or agents, we the undersigned, hereby waive all claims, which might arise from said administration of such medication to said minor child and the results thereof. We agree to indemnify and hold harmless Jackson Local Schools' employees, officers, or agents, from any and all liability relative to the administration of such medication.

I understand I must submit a revised statement and sign it if any information changes prior to the departure of the trip.

Parent/Guardian Signature:_____ Date:_____

Contact Phone #1:_____ Contact Phone #2:_____

rev: 04/14

“LUGGAGE” - the root word being ‘**LUG**’ as in, YOU will lug your own suitcase EVERYWHERE:)
Pack lightly!
Pack smartly!

The magic # limit is 42-50 lbs/suitcase, if it weighs over, you must either unpack & jettison stuff OR pay up to $200 to fly it home
Pack lightly!
Pack smartly!

The average temperature in Northern/Central Europe in the Spring is between 25 - 50 degrees Fahrenheit
Pack lightly!

CLOTHING DOS & DON'TS

- ★ RAINCOAT WITH HOOD
- ★ CLOSE-TOED SHOES WITH TREAD / BOOTS

- ❖ **NO JEANS WITH HOLES**
- ❖ **NO EXPOSED SKIN - NOTHING REVEALING**
- ❖ **NO CLOTHING WITH POLITICAL OR OFFENSIVE SAYINGS OF ANY KIND**

Things to do starting NOW!

1. Check the ACIS website & your account. Please make sure everything is accurate!
2. START practicing your common phrases - hello, good-bye, thank you, please, etc.!!!
3. START reading/researching WHERE we're going & WHAT we'll see!!! The more you know...
4. Talk to your teachers about the trip, what you'll miss (it is the end of the 3rd. Q), upcoming assignments
5. Talk to your employer about the trip and clear any commitments you may have while overseas

- ➢ Do you have your dual voltage appliances ready? hair dryers/flat irons
- ➢ Do you have your adaptors AND converter?
- ➢ Do you have a camera?
- ➢ Do you have a cell phone that will work overseas?
- ➢ How about a quick way to charge your phone?
- ➢ Have you called your bank/credit card company?
- ➢ Have you ordered/bought your Euros? You can do this in the airport, too
- ➢ Have you made copies of your passport, flights & itinerary to leave here in the States?

JOURNALING FOR CREDIT

You will be asked to keep a detailed journal - written or digital - throughout your trip, which will serve as a reflection and will be turned in to either Mrs. Gardner or myself once we return. You will be given back your journal.

Incentive: We are looking for the videographers out there! In conjunction with your journal, we would like ALL cinematographers to create a ‘travel-log’ about our trip. The winning submission will be rewarded with a **$100 iTunes Gift Card.**

MONEY

AUSTRIA - Euro
HUNGARY - Hungarian Forint (HUF) - some places will accept Euros
CZECH REPUBLIC - Czech crown (CZK) - FEW places accept Euros

Choose your currency wisely - you can buy currency (with US $$$) in the airport

CREDIT CARDS

You can use YOUR OWN credit card in Europe, your parents' cards WILL NOT WORK unless YOUR name is on them, PLUS, MANY vendors DO NOT take them, so you will need cash

AND

You need to call BEFORE you leave the states and alert them of your travel dates

You are also charged an exchange rate fee for each transaction

You will also need your federal identification (USA passport) when using your credit card

My ACIS Team

Morgan Crouch
mcrouch@acis.com
1-877-795-0813

BUS 1

Chaperones
Stone/Kathryn Ann
Arter/Rebecca Dawn Loree
Myers/Monica Marie

Balcom/Sophie Taylor
Baumoel/Emerson Lori
Baumoel/Nathan Jeffrey
Bruss/Justin Matthew
Cooper/Marissa Christine
Dorfmueller/Ella Clara
Ehmer/Jessie D
Erbland/Jennifer Sue
Fether/Alyssa Shayne
Heid/Sidney Alexandra
Herrick/Amy Lynn
Herrick/Braden Tyler
Jakubow/Colette Desiree
Markoff/Alexander Robert
Mazziotta/Alexandria Marie
Mcfadden/Samuel James
Moore/Madeline Ava
Morgan/Taylor Marie
Nasvadi/Ethan Michael
Nasvadi/Kendra Nicole
Nicholas/Barbara Jo
Nicholas/Eve Elizabeth
Nicholas/Martin Carl
Owens/Joshua Andrew
Quartz/Mckenzie Elizabeth
Riley/Reena Lynn
Riley/Tessa Jolie
Salomone/Therese Elizabeth
Sedlock/Jessie Elaina
Slesnick/Rachel Margaret
Strunck/Sarah Grace
Webster/Logan Thomas
Zhu/Verna

BUS 2

Chaperones
Ayres Surber/Lisa Suzanne
Gardner/Susan Mary Rinehart
Kracker/Jeffrey Robert

Abrams/Sara Elizabeth
Baker/Alyssa Lorraine
Baxter/Alexandra Nicole
Baxter/Victoria Elizabeth
Bostic/Madyson Mary
De Vaul-Tonges/Lucinda
Dennis/Hailey Noell
Domer/Cassandra Morgan
Dorsey/Sofia Susana
Evans/Madeline Grace
Ferrante/Debra Lynn
Ferrante/Nina Maria
Freels/Avery Elise
Funk/Adelyn Rose
Gardner/Mikayla Marie
Globokar/Adrianna N
Globokar/Angelina H
Globokar/Giavonna F
Hartnett/Katherine Elayna
Hellmann/Isabella Jolynn
Huffman/Michaela Marie
Jodon/Amanda Nicole
Lepsky/Wendy L
Lowmiller/Jessica Lynn
Parshall/Christine Jane
Pelc/Kendra Elizabeth
Sommers/Ashton Grace
Tonges/Bradley Allen
Tonges/Michael Allen
Westphal/Jessica Ann
Westphal/Megan Elizabeth