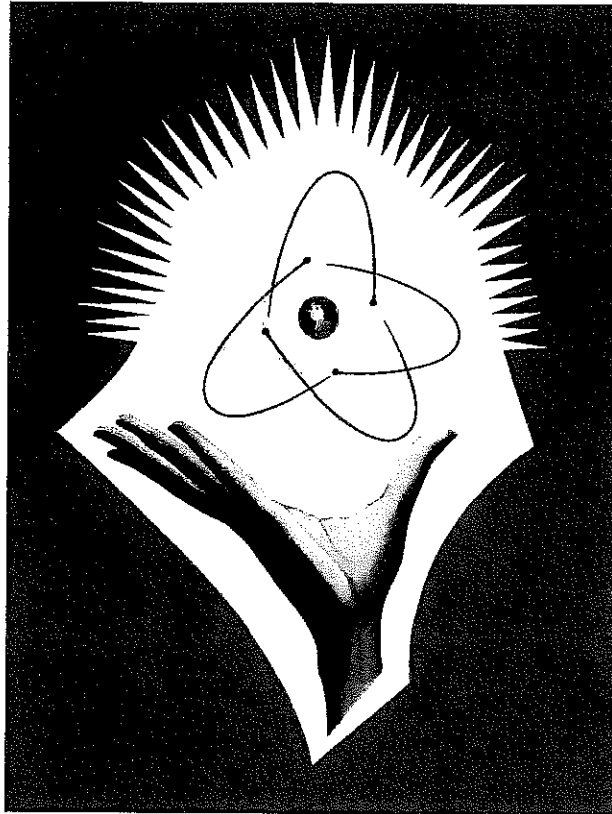


2019 TJMC Commitment Packet



Welcome to TJMC! You are about to become a member of the one the finest musical ensembles in Virginia, and one of the most successful and worthwhile student groups at TJ. Instructions for filling out and turning in this packet are on the back of this page. The packet is due by **June 13th.**

Payments will be done through My School Bucks after you have turned in your paperwork except for extra tshirt orders.

Pay close attention to each form and please read carefully.

INSTRUCTIONS FOR FORMS AND PAYMENTS – Fall 2019

Please read these instructions carefully.

All Forms will also be made available at www.tjbands.org

Round 1 Forms – Due by June 13th

All Finances except extra tshirts will done through My School Bucks – please see the Fee Notice Sheet for payment due dates and instructions

Drop off at rehearsal (preferred) or mail directly to:

Mr. Adam Foreman – TJHSST - 6560 Braddock Road, Alexandria VA 22312

Form 1: Emergency Care Information Form (FCPS Form SS/SE-3, also available online at <http://www.fcps.edu/it/forms/se3.pdf>): Make sure to complete both pages. Will be kept on file all season. Recommend completing the fillable pdf and saving a copy for other school activities, too.

Form 2: Acknowledgement of Commitment Form - Will be kept on file all season. Please review carefully.

Form 3: Extra T-Shirt Order Form - Please include extra shirts when calculating payment on Form 5. The first shirt is free but having a 2nd shirt is a great idea. Shirts can be ordered for parents, siblings, and others. Include a check payable to "TJHSST" for extra shirts

Form 4: TJMC Volunteer Opportunities Form – Critical to the success of TJMC!

Form 5: Medication Authorization Form (FCPS Form SS/SE-63, also available online at <http://www.fcps.edu/it/forms/se63.pdf>): Will be kept on file all season. Recommend completing the fillable pdf and saving a copy for other school activities, too.

Form 6: Medication Information Form – Please complete both sections.

Form 7: Epinephrine Authorization Form – (FCPS Form SS/SE-64, available online at <http://www.fcps.edu/it/forms/se64.pdf>): Complete only if relevant.

Form 8: Inhaler Authorization Form – (FCPS Form SS/SE-65, available online at <http://www.fcps.edu/it/forms/se65.pdf>): Complete only if relevant.

Please complete and return Forms 1-6 even if you think any are not applicable. Thanks!



EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION					
Last:	First:	Middle:	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Grade:
School Name:	ID No.:	Teacher or Counselor :		Bus # (AM):	Bus # (PM):
<input type="checkbox"/> Student has medical alert information on file. See page 2 for details.			Student Cell _____		

PARENT/GUARDIAN CONTACT INFORMATION

This form is to be completed by the enrolling parent. The enrolling parent is the natural or adoptive parent or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Enrolling Parent Last:			First:		Middle:	Telephone
						Home:
Number:	Street:			Apt.#:		
					Work:	
City:			State:	Zip:		Cell:
Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Self			<input checked="" type="checkbox"/> Resides with	Language:	E-mail:	

Other Parent Last:			First:		Middle:	Telephone
						Home:
Number:	Street:			Apt.#:		
					Work:	
City:			State:	Zip:		Cell:
Relationship:			<input type="checkbox"/> Resides with	Language:	E-mail:	

Other Parent Last:			First:		Middle:	Telephone
						Home:
Number:	Street:			Apt.#:		
					Work:	
City:			State:	Zip:		Cell:
Relationship:			<input type="checkbox"/> Resides with	Language:	E-mail:	

Other Parent Last:			First:		Middle:	Telephone
						Home:
Number:	Street:			Apt.#:		
					Work:	
City:			State:	Zip:		Cell:
Relationship:			<input type="checkbox"/> Resides with	Language:	E-mail:	

OTHER CONTACT INFORMATION

Please list at least two people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. These people also have your permission to pick your child up from school during the school day.

Name of Person	Relationship	Language	Telephone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

* Please remember to sign page 2.



EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

FORM 1

CONT.

STUDENT INFORMATION

Last:		First:		Middle:		Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Grade:
School Name:			ID No.:	Teacher or Counselor:			Bus # (AM):	Bus # (PM):
Siblings attending the same school (complete if applicable). Name(s): _____ Name(s): _____				Primary Internet access in the home for this student is <input type="checkbox"/> Cellular <input type="checkbox"/> Broadband <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Declined Do you have a device for this student to use that meets their educational needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined				

CURRENT HEALTH CONDITIONS

Below check any current health condition(s) that EMS or an emergency room physician should know about health of your student. Also complete and submit Health Information form SS/SE-71 if your child has a health condition(s) that require(s) attention during the school day. See below for medical alert information currently on file.

- | | | |
|---|--|---|
| <input type="checkbox"/> allergies (be specific) | <input type="checkbox"/> hemophilia | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> foods _____ | <input type="checkbox"/> physical disability (be specific) _____ | |
| <input type="checkbox"/> medicines _____ | <input type="checkbox"/> respiratory (be specific) _____ | |
| <input type="checkbox"/> bee sting or insect bite _____ | <input type="checkbox"/> seizures | |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> vision problems (be specific) _____ | |
| <input type="checkbox"/> asthma | <input type="checkbox"/> glasses <input type="checkbox"/> contacts | |
| <input type="checkbox"/> cancer | <input type="checkbox"/> other (be specific) _____ | |
| <input type="checkbox"/> diabetes | | |
| <input type="checkbox"/> hearing problems <input type="checkbox"/> hearing aid(s) | | |
| <input type="checkbox"/> heart problems (be specific) _____ | | |

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

MEDICAL ALERT INFORMATION ON FILE

This space reserved for system printing of Health Information

PHYSICIAN INFORMATION

My child's medical care is provided by: _____ (name of doctor, clinic, or HMO) _____ (telephone)

Does your child have health insurance? Yes No

If yes, medical coverage is provided by: _____ (health insurance company, assistance program, HMO, etc.) _____ (telephone)

First aid and emergency treatment will be provided to students in accordance with the current version of FCPS Regulation 2102 or in accordance with the student's individualized health plan.

ENROLLING PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF COMMITMENT**Policy Statement/Participation Agreement**

I understand that I am expected to honor my commitment to this ensemble by being present for all required rehearsals and performances. This includes Home Camp rehearsals (August 5-9), Jumonville Away Camp Trip (August 11-18), and Post Camp rehearsals (August 19-22) as well as after-school fall rehearsals through the first week of November, 2019. I will also participate in all home football game performances and scheduled competitions.

I acknowledge that there are fees associated with participation in this ensemble. There are also innumerable rewards that make the experience very worthwhile. Assistance is available if needed with these fees.

I understand that once I make the commitment to participate in the TJ Marching Colonials for the season, the show is written based on my participation. This means that the show would have to be rewritten at an increased cost to the program if I fail to complete my participation commitment.

I therefore agree to participate fully through the season. If I fail to participate after the June 13th, 2019 deadline, I understand that I will forfeit my fees. I understand that no reimbursement will be given due to the expenses incurred by the Thomas Jefferson Marching Colonials as explained earlier in this packet.

I further understand that no reimbursement can or will be made for extenuating or peripheral purchases that I have made toward my participation. All marchers should understand that both students and parents are party to this agreement, and signatures will indicate acceptance of the terms herein.

Uniform Agreement

I understand that the uniform is the property of the TJHSST Marching Band and that all marchers are required to have my parent/guardian sign this agreement and the uniform receipt that is completed when the uniform is issued.

I understand that I will be issued the uniform pieces listed below and that I am responsible for returning these same items, in undamaged condition. If any of the items are lost or damaged, we will pay the fee for replacement or repair. I agree to make no permanent alterations to any part of the uniform (do not cut fabric – hemming is ok). I will immediately report any stains or damage to my uniform coordinator, without penalty.

Uniform Part	Replacement Cost
Jacket	\$250
Pants	\$100
Gauntlets	\$50
Waist Drape	\$65
Shako (Hat)	\$75
Garment Bag	\$15
Plume	\$30
Jacket Mirror	\$20

Form 2 Cont.

TJMC Rules

While participating in rehearsals for TJMC at the school, away rehearsals at Jumonville, home and away games for the fall season, and all TJMC performances off school grounds, I will accept responsibility for maintaining good conduct, appearance, and hygiene, and I will follow instructions at all times. I understand that my conduct is governed by the "Rules of Conduct and Disciplinary Procedures" outlined in Fairfax County Public Schools Regulation 2601.1P, Student Responsibilities and Rights. A copy of this document is available from the Band Director, and is also on file with the TJHSST principal.

Specifically:

I will not possess or consume any alcoholic beverages, drugs or tobacco while involved with this activity.

I will not participate in any hazing, harassment or any form of initiation or other conduct that endangers the safety or well-being of students, chaperones, and/or staff.

I will abide by all FCPS guidelines when on trips.

I will follow the instructions and published schedules as presented, and understand my responsibility for punctual attendance at all rehearsals and group activities.

I will wear shoes and a shirt to all practices, in the dining hall and elsewhere as appropriate.

I will be in my assigned room and will respect quiet hours at the scheduled times on trips.

If I break these rules, I understand that not only will my parents be called to bring me home from any away venue, but appropriate disciplinary measures, including possible suspension or expulsion, will be imposed by TJHSST and FCPS administrators.

By signing this document, we acknowledge that we have read the above rules and policies and agree to fully comply.

Student Name (Print) _____

Student Signature _____ Date _____

Parent Signature _____ Date _____

**Form 3 – PLEASE ATTACH CHECK FOR EXTRA T-SHIRTS
Checks Payable to “TJHSST”**

SHOW T-SHIRT ORDER (for all TJMC and Parents!!!!)

Print Student Name: _____

Each student will be provided with one 2019 marching season custom-designed short sleeve T-shirt. Additional T-shirts may be ordered for \$10.00 each. These can be ordered to have an extra clean T-shirt ready, and can also be ordered for parents who wish to have one to wear to games and competitions.

Size of (FREE) student T-Shirt: (circle one) S M L XL XXL

Additional T-shirts @ \$10.00 each (for marcher, parent, etc):

 ___ S ___ M ___ L ___ XL ___ XXL Total Additional Shirts ___
 qty qty qty qty qty

Print name of individual to receive additional T-shirt at cost of \$10 each, and relationship to marcher:

- 1.
- 2.
- 3.

Total Payment required (total additional shirts x \$10): \$ _____

Note: These T's will be worn under the uniform as a part of the regulation dress. Having 2 T's is a great convenience when we have a home game on Friday night and a competition the next day & the T-shirt is needed for both.

**PLEASE ATTACH CHECK FOR EXTRA T-SHIRTS
Checks Payable to “TJHSST”**

All other payments will be done through My School Bucks

Form 4

TJMC VOLUNTEER OPPORTUNITIES

TJMC cannot be successful without parental support in key roles including chaperoning during the week away at Jumonville; fitting and organizing uniforms; driving the equipment truck; and helping with fundraising activities.

At Jumonville, chaperone duties include helping with equipment, nursing, filling water bottles, assisting the volunteer nurse, chaperoning social functions, making bed checks and security watches. Parents have as much or as little interaction with their own students as they negotiate. The week is a rewarding and relaxing experience. Please consider volunteering even if only for a part of the week.

Other volunteer opportunities during the band season include pit crew (moving equipment on/off the field for performances at home games and competitions), pep band & competition chaperones, and assisting students with loading and unloading equipment trucks.

Summer Opportunities

I am willing to help as indicated below (check all that apply):

- Fitting, hemming, & organizing uniforms
- Carpentry, welding, or other prop construction
- Check-in for Jumonville trip on Sunday morning, August 11
- Jumonville Chaperone

Circle nights you can be at Orkney Springs and write in your arrival and departure times

Sunday, Aug 11	Monday, Aug 12	Tuesday, Aug 13	Wednesday, Aug 14	Thursday, Aug 15	Friday, Aug 16	Saturday, Aug 17
Chaperone yes/no	Chaperone yes/no	Chaperone yes/no	Chaperone yes/no	Chaperone yes/no	Chaperone yes/no	Chaperone yes/no
Arrive time:	Arrive time:	Arrive time:	Arrive time:	Arrive time:	Arrive time:	Arrive time:
Depart time:	Depart time:	Depart time:	Depart time:	Depart time:	Depart time:	Depart time:

→ Will you ride on the bus with the students? Sun 8/11 (to) yes / no Sun 8/18 (from) yes / no

During the Marching Season

- I can assist with the pit crew: home games (yes / no) away competitions (yes / no)
- I can assist with simple, minor equipment repairs: mechanical (yes / no) electrical (yes / no)
- I can be a chaperone during the school year as needed, please call
- I can assist with fund raising activities
- I can assist with the newsletter and/or other office activities including the music library
- I can videotape events to share with the instructional staff & ensemble
- I can drive the equipment truck as needed, please call
- I can help with carpentry or welding as needed, please call
- I can help with the vetting process for instructional staff
- I will do anything (when I am available), call me!

Print Name (Parent): _____ FCPS Employee? Check here []

Parent telephone: (day) _____ (night) _____ (cell) _____

Parent e-mail: _____ Student Name: _____ Grade _____



MEDICATION AUTHORIZATION

Release and Indemnification Agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I PARENT OR GUARDIAN TO COMPLETE

I hereby request Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless FCPS, FCHD, SACC, and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided FCPS, FCHD, and SACC staff members comply with the physician, parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required.

Has the student taken this medication before? Yes No (If no, the first full dose must be given at home to ensure that the student does not have a negative reaction.)
 First dose was given: Date _____ Time _____

Student Name (Last, First, Middle) _____

Date of Birth	School Name	School Year	Grade
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No School Board employee, public health nurse, or school health aide shall administer medication or treatment, as an exception under School Board policy, unless the principal or his or her designee has personally reviewed all the required clearances.

Parent or Guardian Signature _____ Daytime Telephone _____ Date _____

PART II PARENT OR GUARDIAN TO COMPLETE AND SIGN FOR OVER-THE-COUNTER MEDICATION FOR RELIEF OF SYMPTOMS FOR HEADACHE, MUSCLE ACHES, ORTHODONTIC PAIN, OR MENSTRUAL CRAMPS AND FOR ANTIBIOTIC AND ANTIVIRAL MEDICATION. PHYSICIAN MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS.

The Fairfax County Health Department and Fairfax County Public Schools discourage the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and overnight field trips and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

Diagnosis _____

Medications _____

If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.

Dosage to be given at school or SACC, (e.g. mg, ml, or cc)	Time(s) or interval between times to be given
--	---

Effective date Current School Year From _____ To _____
 If the student is taking more than one medication at school, list sequence in which medications are to be taken

Physician Name (Print or Type)	Physician Signature	Telephone or Fax	Date
--------------------------------	---------------------	------------------	------

Parent or Guardian Name (Print or Type) (Not required if physician signs)	Parent or Guardian Signature	Telephone	Date
--	------------------------------	-----------	------

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check as appropriate

Parts I and II above are complete including signatures. (It is acceptable if all items in part II are written on the physician's stationery or a prescription pad.)

Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent.
 (Within one week after expiration of the physician order or on the last day of school.)

Principal or Designee Signature _____ Date _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. Medications should be taken at home whenever possible so that the student will not lose valuable classroom time or have a shortened lunch period. Any medication taken in school or SACC must have a parent or guardian-signed authorization; some medications also require physician orders. Medication must be kept in the school health room or other school-approved location during the school day. **The parent or guardian must transport medications to and from school, except a high school student may carry an over-the-counter medication to and from the school health room.**
2. No medication will be accepted by school or SACC personnel without receipt of completed and appropriate medication forms.
3. A physician may use office stationery or a prescription pad in lieu of completing part II. Include the following information written in lay language with no abbreviations:
 - Name of student
 - Date of birth
 - Reason for medication or diagnosis
 - Name of medication
 - Exact dosage to be taken in school, (e.g. milligrams per tablet, milligrams per ml/cc) as applicable
 - Time to take medication and frequency or exact time interval dosage is to be administered
 - Sequence in which the medications should be taken in cases where more than one medication is prescribed
 - If medication is given on an as-needed basis, specify the exact conditions or symptoms when medication is to be taken and the time at which it may be given again. ("Repeat as necessary" is unacceptable.)
 - Duration of medication order or effective dates
 - Physician's signature
 - Date
4. All prescription medications, including physician's prescription drug samples, **must** be in their original containers and labeled by a physician or pharmacist. An over-the-counter medication **must** be in the original container with the name of the medication visible. The parent or guardian must label the original container with the following:
 - Name of student
 - Exact dosage to be taken in school (e.g. milligrams per tablet, milligrams per ml/cc)
 - Frequency or time interval dosage is to be administered
5. **The first dose of any new medication must be given at home.**
6. The parent or guardian is responsible for submitting a new form to the school and to SACC at the start of the school year and each time there is a change in the dosage or in the time at which medication is to be taken.
7. Medication kept in the school will be stored in a locked area accessible only to authorized personnel.
8. Within one week after expiration of the effective date on the physician order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.
9. The student is to come to the school health room, or to a predetermined location, at the prescribed time to receive medication. Parents should develop a plan with the student to ensure that the student goes to the school health room at the appropriate time. **Medication can be given no more than one half hour before or after the prescribed time.**
10. The Fairfax County Health Department, Fairfax County Public Schools, and Fairfax County School Age Child Care do not assume responsibility for authorized medication taken independently by the student.
11. In no case may any health, school, or SACC staff member administer any medication outside the framework of the procedures outlined here and/or in FCPS regulations.

Form 6 MEDICATION INFORMATION

Printed Student Name: _____

Please list all prescription and over the counter medication that your child is authorized to carry and administer while on the field trip.

(Note: Physician or Health Care Professional Signature needed on SS/SE-63 Form (Form 7) for prescription medication.)

Name of Medication	Dosage	Prescription or OTC?	Comments

Supplementary Authorization for OTC Medications

I have authorized administration of over-the-counter (OTC) medications on FCPS Medication Authorization form SS/SE-63. The Band Director, staff, nurse, or parent chaperones may provide the following medications to my student if required and requested. My student has never had an allergic reaction to the medications I have authorized.

The volunteer nurse will have the OTC products noted below available on a limited basis.

Check YES or NO on each line; for each entry, you must check either YES or NO. Please do not leave blanks.

- YES_____ NO_____ Advil or Motrin, Ibuprofen, 200-400 mg, every 4 hours for pain or fever
- YES_____ NO_____ Bacitracin ointment with dressing changes for wounds
- YES_____ NO_____ Benadryl, diphenhydramine, 25-50 mg, every 4 hours for allergic reactions
- YES_____ NO_____ Calamine lotion as needed for insect bites or rash
- YES_____ NO_____ Cepacol throat lozenges, 1-2 every 4 hours for sore throat or cough
- YES_____ NO_____ Hydrocortisone cream, 2%, for insect bites or rash
- YES_____ NO_____ Sudafed PE, phenylephrine HCl 10 mg, every 4 hours for nasal congestion
- YES_____ NO_____ Tums, antacid 500 mg, 2-4 tablets every 4 hours for upset stomach
- YES_____ NO_____ Tylenol, acetaminophen, 325-650 mg, every 4 hours for pain or fever

Dated: _____

Parent Signature