

Graduating Class of 2012

Senior Grad Night is Your Chance for an All Night Adventure

All the Details are kept secret
until the buses leave on graduation night.
This event is artfully organized by the professional
event planners, Grad Nights.

EHS Seniors will load buses on June 19th, 2012
and return to EHS the next morning at 6:00 am.

**Pre-sale tickets are offered at \$135
after January they will be \$145**

Questions? Senior Send-off Chair,
Sandra Stull rsendoff@ehsptsa.org

More information to follow
Scholarships are available

Student Name _____

Home Phone _____ Amount Paid _____

Parent Email _____

Are you interested in helping? _____



Make Check Payable to PTSA.

**Return this form at orientation, to the EHS office or mail forms and check to
EHS PTSA 400-228th Ave NE, Sammamish, WA 98074**

PERMISSION TO ATTEND / HOLD HARMLESS AGREEMENT EASTLAKE HIGH SCHOOL CLASS OF 2012 GRADUATION

Your senior has asked to attend our drug-and alcohol-free graduation event. The event is designed to provide a fun, memorable experience that celebrates the culmination of the seniors' hard work and scholastic success. The Parent Planning Committee is committed to keeping it safe, drug- and alcohol-free, and will take all reasonable steps to ensure that the conduct of all seniors is in keeping with this goal. All seniors and their personal belongings will be searched prior to their gaining entry to this event.

In consideration of the services provided by the parents who participated on the Parent Planning Committee, the Howard Group, Inc., d/b/a *Grad Nights®*, and its officers, owners, employees, agents, contractors, entertainers, volunteers and all other persons or entities acting in any capacity on its behalf including the venues who host and provide services at the graduation event (hereinafter collectively referred to as the "Graduation Party Producers"), **the senior and parent/guardian agree as follows:**

I _____ parent/guardian) give my permission for _____ my child/ward, to attend the Senior Graduation Celebration event.

Senior and parent/guardian, agree to abide by the rules and directions established by the Graduation Party Producers. Any senior who is engaging in prohibited or undesirable behavior may be removed from the event, at the sole discretion of the Graduation Party Producers, whereupon the parent/guardian will be contacted and must pick up their senior from the graduation event location. No Refunds will be granted.

The senior and their parent/guardian agree to pay the full replacement cost for any and all losses or damage to any property that is directly or indirectly caused by the senior while participating in the graduation event.

Senior and parent/guardian understand that the Graduation Party is not a school-sponsored event, and that the School assumes no legal liability associated with the event. The senior and their parent/guardian signing this agreement hereby assume all risks associated with attendance and participation at the graduation event and agree to release, covenant not to sue and hold each member of the Graduation Party Producers harmless from any and all claims of any nature which may arise in connection with the graduation event including claims relating to acts or omissions of Graduation Party Producers.

In case of emergency, we their parent/guardian of the senior class member named below authorize all medical, surgical, diagnostic, and hospital procedures as may be deemed necessary and performed by a treating physician.

CONTACT INFORMATION

Student Name: _____	Date of Birth: _____
Parent Names: _____	Address: _____
Home Telephone: _____	Email Address: _____
Emergency Contact, other than parent(s)/guardian(s): _____	
Relationship to Student: _____	Phone Number(s) _____
Other household members who could be relied upon for information in the event of an emergency:	
Adults, 18 and Over: _____	
Young Adults, 14 – 18: _____	
Medications: _____	
Chronic Illnesses/Allergies: _____	Date of Last Tetanus Shot: _____
Insurance Provider: _____	

Additional provisions and signature lines are on the reverse side of this document. Please read all the terms of this agreement, provide the information requested in the contact information section above, and sign the reverse side of this form acknowledging your agreement to all terms set forth on both sides of this document.

Food Allergy Awareness Form

Senior name: _____ Date of birth: _____ Date: _____

Parent/Guardian: _____ Phone: _____ Cell/Work: _____

Health Care Provider treating food allergy: _____ Phone: _____

Do ***you think*** your senior's food allergy may be ***life threatening***? NO YES

Did your senior's ***Health Care Provider*** tell you the food allergy may be (come) ***life-threatening***? NO YES

History and Current Status:

Check the foods that have caused an allergic reaction:

- | | |
|---|---|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Milk or other dairy products |
| <input type="checkbox"/> Peanut or nut butter | <input type="checkbox"/> Soy products |
| <input type="checkbox"/> Peanut or nut oils | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Tree nuts (walnuts, almonds, pecans, etc.) | <input type="checkbox"/> Fish / shellfish |

Other allergies (Please list any other allergens.) _____

How many times has your senior had a reaction? Never Once More than once, please explain:

Does your senior understand how to avoid foods that cause allergic reactions? NO YES

What treatment or medication has your Health Care Provider recommended for use in an allergic reaction?

Have you used the treatment? NO YES

Does your senior know how to use the treatment? NO YES

Please describe any side effects or problems your senior had in using the suggested treatment:

Do you intend for your senior to eat parent party committee provided meals? NO YES

Will your senior be bringing medication / treatment to the party? NO YES

What do you want the parent planning committee to do at the party to help your senior avoid problem foods?

I give my consent to share with the chaperones, that my senior has a life-threatening food allergy.

NO YES

Parent / Guardian Signature: _____ Date: _____

Life-Threatening Food Allergy Emergency Care Plan (ECP)

Student Information			
Student Name:		Life-Threatening ALLERGY to:	
Emergency Contact 1 (Full Name & Phone #):		Emergency Contact 2 (Full Name & Phone #):	
Student should avoid contact with this/ these allergen(s):			
Other allergies:			
School:	Birthdate:	Grade:	Night-of-Event Bus #: <i>Onsite help to enter day of event</i>
Routine medications (at home/school):		Asthmatic? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of last reaction:
Is it medically necessary for student to carry their own EpiPen? <input type="checkbox"/> YES <input type="checkbox"/> NO		High Risk for life-threatening reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Please list the specific symptoms the student has experienced in the past.			
<input type="checkbox"/> MOUTH Itching, tingling, and/or swelling of the lips, tongue, or mouth <input type="checkbox"/> SKIN Hives, itchy rash, and/or swelling about the face or extremities <input type="checkbox"/> THROAT Sense of tightness in the throat, hoarsened and hacking cough <input type="checkbox"/> GUT Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea <input type="checkbox"/> LUNG Shortness of breath, repetitive coughing, and/or wheezing <input type="checkbox"/> HEART “Thready” pulse, “passing out”, fainting, blueness, and pale <input type="checkbox"/> GENERAL Panic, sudden fatigue, chills, fear of impending doom <input type="checkbox"/> OTHER _____			
IF YOU SUSPECT A LIFE-THREATENING ALLERGIC REACTION TO FOOD, IMMEDIATELY ADMINISTER EPINEPHRINE AND CALL 911.			
Medication Doses			
EPIPEN (.03) <input type="checkbox"/>	EPIPEN JR. (0.15) <input type="checkbox"/>	ANTI-HISTAMINE:	
Student May Administer: <input type="checkbox"/> YES <input type="checkbox"/> NO	Student May Administer: <input type="checkbox"/> YES <input type="checkbox"/> NO	_____ CC / MG (circle one)	
Repeat dose of EPIPEN: <input type="checkbox"/> YES <input type="checkbox"/> NO		Side Effects:	
If YES, when:			
Give (list medication) _____ _____ Teaspoons _____ Tablets by mouth		Side Effects:	
Signature of Licensed Health Professional: _____			Date: _____
Printed Name of Licensed Health Professional: _____			
Action Plan			
<ol style="list-style-type: none"> 1. Administer Epinephrine AND CALL 911 (DO NOT HESITATE to administer Epinephrine). 2. 911 MUST BE CALLED IF EPINEPHRINE IS ADMINISTERED. 3. Advise 911 that the student is having a life-threatening allergic reaction AND Epinephrine is being administered. REQUEST ADVANCED LIFE SUPPORT. 4. Note the time of Epinephrine administration: _____ AM / PM 5. Place EpiPen in the container provided AND send with emergency responders along with ECP. 6. Call Parents or other emergency contacts. 			