2025 SENIOR TRIP STUDENT/PARENT CONTRACT

As a student, I have read and discussed the RULES & CONSEQUENCES with my parent(s) and understand these guidelines. I agree to follow these rules.

Student's Name: _____

Student's Signature: _____

Unisex Sweatshirt Size: **S M L XL 2XL 3XL**

Do you have any **special dietary needs**?: YES NO

If yes, please explain: _____

_____

Do you need to **arrive late**? YES NO

If yes, please explain: _____

_____

Do you need to **leave early**? YES NO

If yes, please explain: _____

_____

As a parent, I have read and discussed the RULES & CONSEQUENCES with my son/daughter and support these guidelines. I agree that should removal be necessary, a family member will be available to pick my child up at Camp Cory.

Parent's Name (print): _____

Parent's Signature: _____

Emergency Phone #*: _____

*Someone MUST be available at the emergency number throughout the duration of the trip.

OVERNIGHT FIELD TRIP MEDICATION ORDERS

Destination: YMCA Camp Cory, Penn Yan, NY 14527 **Dates: Tuesday, June 10 - Thursday, June 12** **Advisors:** Megan Goodsell, Elissa Ostrander, Krista Quick

Student Name: **DOB:** **Allergies:**

Check ONE:

☐ My child is NOT bringing any medication on the trip.

☐ My child will be bringing over-the-counter and/or prescription medication for which they have a medication order for independent carry and use on file with the Health Office.
(If this option is checked, please have your child obtain a copy of the form from the Health Office to submit with their trip paperwork.)

☐ My child will be bringing over-the-counter and/or prescription medication and DOES NOT have a medication order for independent carry and use on file with the Health Office.
(If this option is checked, please complete the sections below.)

To be completed by student's Healthcare Provider:

Med: Dose: Route: Frequency: Time: Diagnosis:	Med: Dose: Route: Frequency: Time: Diagnosis:	Med: Dose: Route: Frequency: Time: Diagnosis:
Med: Dose: Route: Frequency: Time: Diagnosis:	Med: Dose: Route: Frequency: Time: Diagnosis:	Med: Dose: Route: Frequency: Time: Diagnosis:

This student has been instructed in and understands the purpose, method and frequency of use for the above medication and, in my judgment, is responsible and may independently carry and use the medication, unless stated otherwise. Staff intervention is needed only during emergencies.

MD's Name (please print): **MD's Signature:**

MD's Phone Number: **Date:**

To be completed by student's parent/guardian:

My child may independently carry and use the above medication as ordered. I will send only the amount of medication needed for the trip.

My child and I understand that he/she is subject to suspension from school if medication is shared with others or used in an irresponsible manner.

I give the chaperone my permission to administer any medication that is not to be carried by my child as ordered above.

Parent's Name (please print): **Parent's Signature:**

Parent's Phone Number: **Date:**

Trip dates: 6/10/2025 -6/12/2025 **Destination:** YMCA Camp Cory	**OVERNIGHT FIELD TRIP EMERGENCY MEDICAL INFORMATION**	**This form must be submitted by due date:** May 27

Student _____ Birthdate _____ Gender: M F Grade _____ Phone _____

Father/guardian _____ Address _____ Phone (1) _____ (2) _____

Mother/guardian _____ Address _____ Phone (1) _____ (2) _____

Other _____ Phone _____ Relationship to child _____

Primary Care Physician _____ Address _____ Phone _____

Insurance Provider _____ Subscriber Name _____ Policy # _____

MEDICAL INFORMATION

Allergies: Yes No **Seizures**: Yes No **Asthma**: Yes No **Diabetes**: Yes No **Contact Lenses**: Yes No **Other**: _____

Does your child have any physical disabilities or conditions which may limit his/her participation in this activity? Yes No

If yes, explain: _____

MEDICATIONS: Are there any prescription or OTC medications (besides those listed below) that the student will need to take on this trip? NO YES (see below)

1. An **Overnight Field Trip Medication Order Form** must be completed by a healthcare provider for all prescription and OTC medications not listed below EXCEPT for those medications for which Independent Carry and Use orders are on file for the current school year.
2. Students who carry unauthorized medications or share medication with other students are subject to suspension from school.
3. Medications must be in the manufacturer's container or pharmacy Rx bottle and contain only the amount required for the trip.
4. **Overnight Field Trip Medication Order Form** and medications to be administered by the chaperone(s) must be submitted prior to the trip.

CIRCLE medications authorized (school provides): ***I authorize the chaperone to give my child the following medications as prescribed by the District MD:***

Loperamide (Imodium) for diarrhea	**Acetaminophen** (Tylenol) for pain or fever	**Cough Drops** for cough or sore throat
Ibuprofen (Motrin/Advil) for pain or fever	**Meclizine** (Dramamine/Bonine) for motion sickness	**Antacid** (Tums) for upset stomach

STUDENT/PARENT CONTRACT **I agree to:**

1. Cooperate fully with chaperones, teachers and all other administrative officials.
2. Neither use, not have in my possession at any time, alcoholic beverages, illegal drugs or any other item that violates the Student Code of Conduct.
3. Not carry medication unless I have provided the required **Overnight Field Trip Medication Order Form**. I agree to adhere to all medication guidelines as stated on this form.
4. Not break the curfew and abide by all rules regarding being in a room with a person of the opposite gender behind closed doors. I understand that this is not permitted.
5. Not participate in pranks or vandalism of any kind. If I damage property, my parents and/or I will assume full financial responsibility.
6. I understand that if I choose *not* to abide by these rules, my parents will be called and I may be sent home at their expense. Further disciplinary action will be taken.

If none of the above names can be reached, please call an available licensed physician. You may take my child to the nearest Emergency First Aid station by ambulance, if necessary. This authorizes treatment of my child by a physician/hospital in case of an emergency. I certify that the above Medical and Contact information is accurate and I understand that it will be relied upon by the Webster Central School District.

_____ _____ _____

Signature of Parent/Legal Guardian Signature of Student Date