Foxborough Regional Charter School
Field Trip Permission Slip

Field Trip Destination: Nature's Classroom

Date of Field Trip: October 28 - 31

Leaving school at: 8:30 am Oct. 28

Returning at: 12:00 pm Oct. 31

Total cost of trip per student: $ 325

Please return this form by: September 20, 2019

If your family is unable to afford the cost of this trip, please contact the FRCS Business Office in writing to request financial assistance.

I the undersigned student aged 18 or over, or parent or lawful guardian of (student's full name) _____ a minor, do hereby consent to his/her participation in the attached field trip, a voluntary program offered by the Foxborough Regional Charter School on the date of _____ and do forever RELEASE, acquit, discharge, and covenant to hold harmless the Foxborough Regional Charter School, its officers, agents, employees and attorneys from any and all actions, causes of action, and claims on account of, or in any way growing out of, directly or indirectly, all known and unknown personal injuries or property damage which (student's full name) _____ and/or I as the parent of said minor may now or hereafter have, and also all claims or right of action for damages which said minor has or hereafter may acquire, either before or after he/she has reached his/her majority growing out of or resulting from his/her participation in the aforementioned activity sponsored by the Foxborough Regional Charter School.

_____ _____

Signature of parent/guardian or student 18 or over Date

_____ _____

Signature of student Date

NATURE'S CLASSROOM STUDENT REGISTRATION

Please print all information and please fill in all the blanks

Child's Name_____ Date of Birth _____
(Last) (First)

Age _____ Sex _____ Weight _____ Height _____

Address_____
(No. and Street) (Town) (State) (Zip)

Parent's Name(s)_____

Email Address _____

Home Telephone (____) _____ Alternate Telephone (____) _____

Family Physician _____ Telephone (____) _____

I give permission for (Name) _____to attend Nature's Classroom

for the period of _____as part of the outdoor education program

of (School Name) _____ . I understand that the director of Nature's Classroom may, if necessary, for my child's health, have him/her hospitalized or use outside medical, surgical, or dental care. I also understand that the director and/or school leaders may dismiss my child from Nature's Classroom if, in their opinions, his/her conduct or influence is not in the best interest of the entire group. No refund is given if such action is taken for discipline reasons. Nature's Classroom has my permission to use my child's image, voice and/or likeness for promotional purposes.

Date _____ Signature _____ Relationship_____

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MEDICAL PERMISSION SLIP

Should your child become ill, get a headache, catch a cold or have other minor medical or dental problems, do you give permission for the administration of basic first aid at the discretions of the Nature's Classroom staff?

Yes____ No____

Date _____Signature _____ Relationship_____

.....

If Ibuprofen or Tylenol needs to be administered, do you prefer:

IBUPROFEN_____ TYLENOL_____ OTHER (Specify) _____

Nature's Classroom

HOME AND HEALTH INFORMATION QUESTIONNAIRE

Child's Name: _____ Date of Session: _____

The questions below are provided to give you a framework within which to provide that needed information to us. Please feel free to add whatever information you think will be helpful – attach additional sheets if necessary. We will share this information with your child's classroom teachers prior to his/her arrival at camp. Thank you for your cooperation.

1. Is this your child's first prolonged stay away from home? _____
2. Is this your child's first sleep away experience? _____
3. Has your child ever had a problem with homesickness? If yes, please explain briefly. _____

   _____

   _____
4. Does your child have a bed wetting problem? _____
5. Date of last tetanus booster shot (not a tetanus shot given after an injury). _____
6. Are there any restrictions on your child's activities? Please include any special health concerns, e.g., special diet, recent hospitalizations, fractured bones, etc.

   _____

   _____

   _____
7. List any allergies, e.g., food, environmental, medication, and explain degrees of severity and current treatment.

   _____

   _____

   _____
8. Does your child have any sensory, physical or cognitive disabilities? ☐ Yes ☐ No If yes, explain.

   _____

   _____

   _____
9. Has anything happened recently in your child's life that may affect him/her emotionally or physically while at camp? If yes, please explain.

   _____

   _____

   _____
10. Additional information:

    _____

    _____

    _____

    _____

Nature's Classroom

MEDICATION ADMINISTRATION FORM

<u>All medications</u> (including prescription, non-prescription and vitamins) <u>must come in original containers.</u>

Please complete *all parts* of the following chart for all medications being sent or the medication cannot be administered. If more than four medications are needed, please copy this page.

CHILD'S NAME: _____

I hereby give permission for the staff of Nature's Classroom to oversee the administration of the following medication(s) to my child:

Medication	Dose (mg, tsp)	Time Medication Taken				
		Breakfast	Lunch	Dinner	Bed	Other

Comments (reason for taking medications, special considerations): _____

_____

_____

_____

Your child will not be allowed to keep any medication in his/her cabin. Prescribed medications must be in original container with pharmacy label containing Rx number, the name of the medication, the dosage, directions for administration, and the child's name. Whenever possible, a copy of the doctor's prescription or letter may be sent to clarify any discrepancies. All non-prescription medication must be in their original containers, clearly labeled with the child's name, name of the medication and direction for use.

Signed: _____ Dated: _____

Relationship: _____

HARRINGTON MEMORIAL HOSPITAL
SOUTHBRIDGE, MASSACHUSETTS

GENERAL MEDICAL CONSENT FOR TREATMENT OF MINORS IN THE EMERGENCY ROOM

In case of accident or illness, I/we hereby authorize the physician and personnel at Harrington Memorial Hospital to examine and administer such treatment, medication and procedure(s) found to be necessary for the diagnosis and treatment of my/our son/daughter.

Name: _____ Date of Birth: _____

Exceptions: (If none, so state): _____

Date(s) this consent is in effect: _____ through: _____

The explanation of the medical problem will be made to the patient and/or the person who accompanies my/our offspring to the hospital. One or both of them shall sign the informed consent.

PARENT OR GUARDIAN MUST SIGN HERE:

Date: _____ Signed: _____
(Relationship)

Date: _____ Signed: _____
(Relationship)

Witness: _____

Patient's family physician: _____

Allergies: _____

Date of last tetanus immunization: _____

Pertinent medical conditions: _____

Medications presently being taken: _____

_____

Medical insurance/person responsible for payment: _____

_____

Policy #: _____

A photostat copy of this form is to be attached to each emergency record. This consent is to be kept in the permanent file if used. It is only valid for a **one month** interval.

Nature's Classroom Chaperones Wanted!

Dear Parents,

Our Nature's Classroom trip is fast approaching and the fifth grade team will soon begin the process of selecting parents to chaperone. Although we are unsure as to how many male and female chaperones will be needed, we would like to get an idea of who is interested and able to join us for this amazing experience.

Chaperones must be available Monday, October 28 to Thurs. October 31. Also, each chaperone will need to cover meals, room and board costs (approximately $100). All chaperones must complete a CORI form (with copy of both sides of a driver's license) in order to attend the trip. If you are interested, please return the bottom of this letter to your child's homeroom teacher, **with the CORI form (available on the school website) and a copy of your driver's license, AS SOON AS POSSIBLE!** Chaperones will be picked randomly and you will be contacted by the team if chosen. The team will then call a meeting for the chaperones to discuss Nature's Classroom routines and procedures and important information. We understand the commitment it takes to be a Nature's Classroom chaperone, and we truly thank you in advance for your interest.

Sincerely,
The Fifth Grade Team

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*Please fill out this section **ONLY** if interested in chaperoning for Nature's Classroom

Parent's Full Name: _____

Email address: _____

Best Contact Number: _____

Child's Full Name: _____

Homeroom Teacher: _____

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Foxborough Regional Charter School

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CORI REQUEST FORM

Foxborough Regional Charter School has been certified by the Criminal History Systems Board for access to all criminal case data including conviction, non-conviction and pending. As an applicant/employee for the position of * _____, I understand that a criminal record check will be conducted for conviction, non-conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

*

Applicant/Employee Signature

APPLICANT/EMPLOYEE INFORMATION (PLEASE PRINT)

*	*	*
LAST NAME	FIRST NAME	MIDDLE NAME
*		*
MAIDEN NAME OR ALIAS (IF APPLICABLE)		PLACE OF BIRTH
*	***	
DATE OF BIRTH	SOCIAL SECURITY #	ID Theft Index PIN (if applicable)*

*

MOTHER'S MAIDEN NAME

(Requested but not required)

FORMER ADDRESSES:_____

SEX:_____ HEIGHT:___ ft. ___ in. WEIGHT: _____ EYE COLOR: _____

STATE DRIVER'S LICENSE NUMBER:_____

***THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION:

REQUESTED BY:_____

SIGNATURE OF CORI AUTHORIZED EMPLOYEE

*The CHSB Identity Theft Index PIN Number is to be completed by those applicants that have been issued an Identity Theft PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process.

All CORI request forms that include this field are required to be submitted to the CHSB via mail or by fax to 617-660-4614.