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Olmsted Falls Middle School

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January 28, 2015

Dear Parents:

It is hard to believe the trip to Washington D.C. is just over eight weeks away! The trip will begin on Wednesday, April 8, with the return date of Friday, April 10. The cost includes a three-day, two-night stay at the Westfields Marriott Hotel (14750 Conference Center Drive, Chantilly, Virginia 20151, 703-818-0300), and includes all meals, admission to the National Museum of the Marine Corps, the estate of George Washington at Mount Vernon, Smithsonian Museums, a dinner cruise along the Potomac River, and a panoramic group picture.

We have scheduled a parent and student meeting for **Wednesday, February 4, 2015, from 7:00-8:00 PM** in the OFMS Cafetorium. At this time a representative from Jerry Nowak Tours and Mr. Kurz will discuss the itinerary, the amount of spending money to bring, and other important information. This meeting will also be an opportunity for you to ask any questions you may have. **It is very important that at least one adult from each household attend.**

Final payment is due by February 6, and will be collected at the parent meeting on February 4. Final payment can be made by check during 8th grade lunch the week of February 2-6. Online payments are accepted at EZPay: www.spsezpayolmstedfalls.com.

The following forms are being sent home with all 8th graders on Wednesday, January 28, and is being emailed to all parents on Thursday, January 29, and must be returned when you attend the meeting on February 4. The medication form is only due if your child will be taking medication while on the trip; it is due by Friday, March 13, 2015.

Please complete the required forms that are attached and return by due date as indicated:		
Form	**Purpose**	**Due Date**
Form A: Trip Permission Form	Permission for your child to participate in the trip. **(Required)**	February 6
Form B: Medical Release Form	Permission to obtain medical treatment if necessary. **(Required)**	February 6
Form C: Parental Responsibility Form	Parent and student statement accepting responsibility for transportation in the event removal from the trip is necessary because of inappropriate behavior. **(Required)**	February 6
Form D: Permission to Administer Tylenol Form	Permission to administer Tylenol if needed for headache, abnormal temperature and/or minor discomfort. School will provide Tylenol. **(Optional)**	February 6
Form E: Cell Phone Authorization & Expectations	Acknowledgement that cell phone expectations are understood and will be followed as written. **(Required)**	February 6
Emergency Contact Information	Need current emergency contact information for phone chain. **(Required)**	February 6
Medication Form	Authorization to administer medication if needed. **(Only if medication administered by staff while on trip.)**	March 13

Please feel free to contact me at 440-427-6201, or at mkurz@ofcs.net, if you have any questions.

Sincerely,

Mark E. Kurz
Principal

REQUIRED

OFMS WASHINGTON DC TRIP MEDICAL RELEASE FORM

(SECTIONS A & B MUST BOTH BE COMPLETED)

STUDENT: _____ PHONE #: _____

ADDRESS: _____ HOMEROOM #: _____

SECTION A - PARENT OR GUARDIAN APPROVAL FOR SCHOOL TRIP

I give my daughter/son permission to attend the Board of Education approved school trip to Washington, D.C. from Wednesday, April 8 - Friday, April 10, 2015. I further understand that the following activities associated with this trip are such that school staff cannot directly supervise my child during certain segments of the trip (i.e. George Washington Estate at Mount Vernon, National Mall, National Museum of the Marine Corps, Smithsonian Museums, Pentagon City Mall and Food Court, Reagan Food Court, and Hotel Room from 10:30 PM-8:00 AM). I understand that it may be necessary to share pertinent educational and/or medical information with staff and parent chaperones as it relates to the well-being of your child. In light of the above, I hereby give consent to my child's participation in the trip and in the unsupervised activities.

PARENT SIGNATURE_____ DATE: _____

SECTION B – EMERGENCY MEDICAL AUTHORIZATION

PURPOSE: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

PART I OR PART II MUST BE COMPLETED
PART I - TO GRANT CONSENT FOR TREATMENT

In the event reasonable attempts to contact me at _____(Phone #)

or other parent, _____ at _____(Phone #) have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by a physician or dentist and/or the transfer of my child to any hospital that is reasonably accessible both to, from and in Washington DC.

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 before the surgery is performed. Facts concerning the child's medical history including allergies, medications being taken, and physical impairments to which a physician should be outlined below:

PARENT SIGNATURE:_____ DATE_____

PART II - REFUSAL TO CONSENT FOR TREATMENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I want the school authorities to TAKE NO ACTION or to follow this procedure:

_____

PARENT SIGNATURE:_____ DATE_____

**PLEASE COMPLETE SECTION C ON REVERSE SIDE **

REQUIRED
SECTION C - PARENTAL RESPONSIBILITY

I understand I am solely responsible for my child's transportation home, and/or any cost of such transportation home, in the event he/she engages in behavior that could result in possible suspension/expulsion as written in the Olmsted Falls Middle School Handbook. Such offenses include, but are not limited to:

- Destruction of property
- Gross insubordination to any adult
- Harassment of another individual
- Not adhering to any expected behaviors of an Olmsted Falls Middle School Student as described in the Student Handbook.

We ask that you speak to your child regarding this policy and sign below that you will accept responsibility for his/her behavior by adhering to the removal request should it be deemed necessary.

_____ _____

Parent Signature Student Signature

_____

Date

Please Note: This section must be signed along with the appropriate signatures on the front in Section A and B (Part I OR Part II). Failure to sign any section will exclude your child from participating in the Washington DC trip.

OPTIONAL
SECTION D - PERMISSION TO GIVE TYLENOL (ACETAMINOPHEN)

In case your child needs Tylenol (Acetaminophen) but did not bring it from home, the school will provide, *for this field trip only*, Tylenol in pill form (no liquids available). **Please circle YES or NO below.**

I give permission for my child, _____, to take Tylenol (according to bottle directions) for a headache, abnormal temperature, and/or minor discomforts.

YES **NO**

Comments:

Parent/Guardian Signature _____

(REQUIRED -- Will not be given without signature)

All other medication requires completion of School Medical Form (See Pink Sheet).
ANY NON-PRESCIPTION DRUG REQUIRES ONLY A PARENT SIGNATURE.
ANY PRESCRIPTION DRUG REQUIRES BOTH PARENT & DOCTOR SIGNATURE.

REQUIRED

SECTION E: WASHIGNTON DC CELL PHONE USE AGREEMENT

Student's Name:		Student's Cell Number:
Team:	Homeroom Number:	Parent's Name:

We understand the following cell phone use guidelines and further understand what the consequences will be if my child does not follow the guidelines as outlined:

1. This form must be completed with all requested information as outlined above and below and must be returned to Mr. Kurz by Friday, February 6, 2015.
2. My child will not use his/her cell phone while any adult is presenting/addressing him/her while in a group setting or individually while on this trip.
3. My child will not use (text, call, message, game, access the Internet, and any other such related actions) his/her cell phone in any manner which brings intended or unintended harm on another student in our group or with any other student or group while we are on this trip.
4. My child understands that if his/her cell phone is taken by an adult on the trip that he/she will not receive their cell phone back until they serve a two hour Saturday Detention from 8:00-10:00 AM on Saturday, April 18, 2015. The Saturday Detention will cause the student to earn 3 points towards the trip to Cedar Point. At 5 points, the student would lose the trip to Cedar Point.
5. We understand that if my child takes his/her cell phone on this trip without returning this **SECTION E: WASHIGNTON DC CELL PHONE USE AGREEMENT** form, he/she will lose the trip to Cedar Point, which will be held on Friday, May 29, 2015.
6. We understand that Olmsted Falls Middle School or any other adult associated with this trip are not responsible for any loss, damage, or theft of my child's cell phone.
7. We understand that my child is responsible for the care of his/her cell phone.
8. We understand that use of a cell phone in an inappropriate manner as it relates to our Board adopted Student Code of Conduct may also result in additional discipline, up to and including, Office Detention, Saturday Detention, Out of School Suspension, and Expulsion from School.

Parent Signature: _____
Student Signature: _____
Date: _____

Please check one box below as this form is incomplete and invalid if not filled out completely.

☐ My child **WILL** be bringing his/her cell phone on the trip to Washington DC.

☐ My child **WILL NOT** be bringing his/her cell phone on the trip to Washington DC.

These forms must be returned with final payment by Friday, February 6, 2015

OLMSTED FALLS M IDDLE SCHOOL
WASHINGTON DC TRIP
APRIL 8-10, 2015

EMERGENCY CONTACT INFORMATION FORM

The information that you provide below will be used to develop a phone tree chain to use as a system to communicate with parents while we are in Washington DC. Please understand that the information that you provide will be shared with a parent volunteer Phone Captain who will be responsible to contact 10-15 parents should we need to share information with you during the trip. Please indicate below whether or not you would be interested in being a Phone Captain. Thank you.

Student Information			
Student's Last Name:		Student's First Name:	
Student's Date of Birth:		Home Telephone Number:	
Team:		Homeroom Number:	
Custodial Parent or Guardian Information			
Name:		Relationship:	
Daytime Phone:	Evening Phone:	Cell Phone:	Pager:
Name:		Relationship:	
Daytime Phone:	Evening Phone:	Cell Phone:	Pager
Name:		Relationship:	
Daytime Phone:	Evening Phone:	Cell Phone:	Pager:
Friend, Relative or Childcare Provider			
Name:		Relationship:	
Daytime Phone:	Evening Phone:	Cell Phone:	Pager:
Name:		Relationship:	
Daytime Phone:	Evening Phone:	Cell Phone:	Pager:

☐ I would be willing to serve as a Phone Captain to make 10-15 phone calls should the need arise while the students are in Washington DC.

Name:_____ Daytime Phone Number:_____ Email Address:_____

Olmsted Falls Middle School
Washington DC Trip
April 8-10, 2015

LUGGAGE SEARCH CONFIRMATION FORM

April 7, 2015

Dear Parent(s):

By signing below, parents certify that they have checked their child's entire luggage and are sure that no prohibited items are contained therein.

Failure to have this form with the student on the day of our trip will require that OFMS staff search your child's luggage.

Student Name (Print): _____

Parent/Guardian Signature: _____

Please be sure that your child brings this form with him/her to the OFMS Cafetorium at 6:00 AM on Wednesday, April 8, 2015. We are departing at 6:30 AM.

Please contact me in the event you have any questions or need additional clarification.

Thank you,

Mark E. Kurz

OFMS Staff Member's Signature: _____
(To be completed on April 8, 2015)

MEDICATION FORMS

WASHINGTON DC MEDICATION FORMS: RETUN BY MARCH 13, 2015

Please check appropriate school:

☐ Early Childhood Center ☐ Falls-Lenox Primary

☐ Intermediate ☐ Middle School ☐ High School

NON PRESCRITION OR OTC MEDICATION

The administration of NON prescription medication/over the counter medication requires only a parent authorization and request. All non prescription medications must be administered according to the package instructions for directions and dosage, other wise it will require a physician's signature. **Please Use Form A**

PRESCRIPTION MEDICATION

The administration of any prescription medication requires both Parent **and Physician Authorization. Please Use Form B**

USE OF MEDICATION GUIDELINES

1. **All medication** must be delivered by a parent or responsible adult in the container provided by the pharmacy.

2. **All** medications that a student needs will be locked in the clinic or in a secure location, except for asthma inhalers and epi-pens

3. Medication forms are valid for the current school year only. Unused medication will be discarded ten (10) days after the last day of school, unless claimed by a parent.

4. All forms may be faxed or hand delivered by a responsible parent

5. Medications for chronic conditions are included in the Health Care Plan. For example: Inhalers and epi- pen authorizations are included in the asthma / allergy Health Care Plans

6. Generally, it will be the Health Care Team's responsibility to give the child his/her medication. If it is not the specified time as stated within, the Team member responsible for administering the medication will make reasonable efforts to locate the student and administer the medication, or alternatively provide the parent with notification of the missed dosage.

FORM A **Request for Administration of *Non Prescription* /over the counter Medication**

DATE _____ GRADE _____

STUDENT'S NAME _____
(Please Print)

TYPE OF MEDICATION _____

DOSAGE/Mg _____ TIME _____

FROM _____ TO _____
(Date) (Date)

Reasons for Medication _____

Comments or Concerns _____

I hereby request that my child, _____ be given the above medication. This medication will be given **according to package instructions**. Requests for dosages above those indicated on the package require physician authorization.

It is understood that the Board of Education of the Olmsted Falls School District, its officials, agents, and contracted employees (PSI Affiliates and employees) or any of its school personnel shall be held harmless from all liability for damages or injury, resulting from the administration of such medication.

BY SIGNING THIS AUTHORIZATION, I UNDERSTAND AND AGREE TO ABIDE BY THE OLMSTED FALLS "USE OF MEDICATIONS" ADMINISTRATIVE GUIDELINES (Described on Previous page)

_____ _____
Printed Name of Parent Date

_____ _____
Signature of Parent Phone No.

FORM B Request for Administration for Prescription Medication

DATE _____ GRADE _____

STUDENT'S NAME _____
(Please Print)

TYPE OF MEDICATION _____

DOSAGE/Mg _____ TIME _____

FROM _____ TO _____
(Date) (Date)

Reasons for Medication _____

Comments or Concerns _____

I hereby request that my child, _____ be given the above

Medication as Prescribed by Dr. _____

Procedure required for administration, including times or intervals at which each dosage is to be administered: _____

Any special instructions, including storage or sterility requirements: _____

Severe reactions that should be reported to the Physician _____

Severe reactions that may occur to another child for whom the medication is not prescribed, should another child receive a dose of the medication: _____

If the medication is an inhaler or epinephrine auto-injector, procedures that should be followed in the event the medication does not produce the expected relief from the student's asthma attack or anaphylaxis: _____

It is understood that the Board of Education of the Olmsted Falls School District, its officials, agents, and contracted employees (PSI Affiliates and employees) or any of its school personnel shall be held harmless from all liability for damages or injury, resulting from the administration of such medication.

BY SIGNING THIS AUTHORIZATION, I UNDERSTAND AND AGREE TO ABIDE BY THE OLMSTED FALLS "USE OF MEDICATIONS" ADMINISTRATIVE GUIDELINES (described on previous page)

Parent's printed name _____ Phone _____

Parent's Signature _____ Date _____

Physician's printed name: _____ Phone _____

Physician's Address: _____

Physician's Signature: _____ Date: _____