

Field Trip Authorization Form

Name of Group/Team: **WORLD AFFAIRS COUNCIL / UNIVERSITY OF CONNECTICUT MODEL UN**

Faculty/Staff member Making Request: **MELISSA OLIVER**

Date(s) of Proposed Trip: **11/08 - 11/10** # of School Days: **2** # Nights Away: **2**

Destination: **STORRS, CT** Distance (one-way): **185 MILES**

Purpose/Benefit of Trip: **UCMUN (MODEL UN SIMULATION)**

Transportation Arrangements: **SCHOOL BUS**

Students: **19** # Chaperones: **2** School Staff: **1** Parents/Other: **1**

Arrangements for Mixed Gender Supervision: **YES**

Cost Per Student: **\$225.00 OR LESS**

Description of any Fundraising: **SALES / RAFFLES DURING CONFERENCES**

Do all members of the group/team have an opportunity to participate? Yes No

If "no," describe circumstances:

For overnight trips

All parent/other chaperones have attended volunteer training: Yes No

Date and time of pre-trip chaperone meeting: **THURSDAY, NOVEMBER 1ST, 7:30 AM ROOM 307**

For out-of-country trips

Travel and cancellation insurance arrangements (attach copy of contract with insurance and cancellation provisions highlighted):

Approvals:

Principal or Athletic Administrator _____
Superintendent _____
School Board _____

Date 10/3/2012
Date _____
Date _____

Authorization Authority: Principal/AA: in-state day trips; Superintendent: out-of-state trips w/n 125 miles, in-state trips requiring one-night stay; School Board: out-of-state trips beyond 125 miles, trips requiring 2 or more overnights; trips costing \$500 or more per student

Field Trip Authorization & Parent Consent Form

CLASS / GROUP: World Affairs Council

TRIP NAME: University of Connecticut Model United Nations Simulation

TEACHER / STAFF TRIP LEADER: Melissa Oliver

DATE(S) OF TRIP / DESTINATIONS / TIMES

DATE: 11/08 - 11/10

DESTINATION: Storrs, CT (UCMUN - Model U.N. Simulation)

ANTICIPATED DEPARTURE TIME: 10:00 a.m. (Thursday)

ANTICIPATED RETURN TIME: 10:00 p.m. (Saturday)

STUDENTS ATTENDING: 19 (nineteen) # **CHAPERONES (INCLUDING LEADER)** 2 (two)

TRANSPORTATION WILL BE BY: School Bus

DRIVERS (IF OTHER THAN SCHOOL BUS DRIVERS OR COMMERCIAL CARRIERS): N/A

IN AN EMERGENCY, HOW CAN GROUP LEADER BE CONTACTED: Melissa Oliver (Cell Phone: # (603) 233 - 7693)

OTHER THINGS YOU SHOULD KNOW:

FOR TRIPS INVOLVING OVERNIGHTS:

WE WILL BE STAYING AT: Best Western Regent Inn

ADDRESS: 123 Storrs Road, Mansfield Center CT

PHONE #: (860) 423-8451

PROVISIONS FOR MIXED GENDER SUPERVISION: Yes

PRE-TRIP PARENT MEETING FOR TRIP INVOLVING THREE (3) OR MORE OVERNIGHTS:

WE WILL HOLD A PRE-TRIP PARENT MEETING AS FOLLOWS:

DATE: 11/01/12 **TIME:** 7:30 a.m. **PLACE:** CEHS Room 307



CLASS / GROUP: WORLD AFFAIRS COUNCIL **TEACHER/STAFF LEADER:** MELISSA OLIVER
TRIP NAME: UCMUN - University of Connecticut Model United Nations Simulation

PARENT / STUDENT CONSENT

I hereby give my permission for _____ (son/daughter name) to participate in the field trip(s) named and described above. I acknowledge receipt of the Field Trip Information form for that trip(s). I am comfortable with the arrangements described. I authorize the trip leader(s) to arrange medical treatment in an emergency. I hereby release the trip leader, the field trip(s) chaperones, the school, and the school department ("School"), town of Cape Elizabeth ("Town"), and all of their agents or employees, from any and all claims, liabilities and responsibilities for damages or injuries that my son/daughter may experience during this trip, except only any claims for any damages or injuries that may be sustained as a result of any intentionally harmful acts on the part of the trip leader, the chaperone(s), the Town, the School, or their agents or employees.

Parent Signature

Student Signature (if 18 or older)

Date

Date

EMERGENCY CONTACT AND MEDICAL INFORMATION FORM

Student Name: _____

Birth Date: _____

Emergency Contact Information:

1st Parent Contact: _____

Work Phone: _____

Home Phone: _____

Cell Phone: _____

2nd Parent Contact: _____

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Non-Parent Contact: _____

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Known Allergies / Treatment Protocols:

Other Medical Conditions:

Medications:

Medication or Treatment Restrictions:
