


STUDENT TRAVEL/ FIELD TRIP AUTHORIZATION FORM**AUG 09 2016**Group/Team Name: CEHS Model United NationsName of Faculty/Trip Leader Making Request: Melissa OliverDate(s) of Proposed Trip: Nov. 11th - Nov. 13th # of School Days: none # Nights Away: TwoTrip Destination: Providence, Rhode Island Distance (one-way): 160 milesPurpose/Benefit of Trip: BUSUN (Brown University Simulation of the United Nations)Transportation Arrangements: CEHS Bus Transportation from CEHS to/from hotel & confere# Students: 20 # Chaperones: 2 (including Ldr) School Staff: 1 Parents/Other: 1Arrangements for Mixed Gender Supervision: yesCost Per Student: \$225.00 or lessDescription of any Fundraising: Fundraisers (i.e. Trivia Night) throughout academic year

Do all members of the group/team have an opportunity to participate?

If not, describe circumstances: Yes**FOR OVERNIGHT TRIPS:**All parent/other chaperones have attended volunteer training: yesDate/time of pre-trip chaperone meeting: N/A**FOR OUT-OF-COUNTRY TRIPS:** Travel and cancellation insurance arrangements (attach copy of contract with insurance and cancellation provisions highlighted).**APPROVAL OF TRAVEL:**

Principal or AD:  Date August 4, 2016

Superintendent: _____ Date _____

School Board: _____ Date _____

- All travel must first be approved and recommended by the principal or, in the case of athletic trips, the athletic administrator. The principal and athletic administrator are permitted to approve in-state day trips (no overnight stays) without the endorsement of the Superintendent or School Board.
- Out-of-state trips within New England and in-state trips requiring no more than one night's stay must be approved by the Superintendent.
- Board approval is required for trips outside of New England; for all trips requiring two or more overnight stays; and for all trips requiring a per-student cost or fund-raising of \$500 or more.
- Travel requests needing approval from the Superintendent or Board should be submitted at least two months in advance of the trip.

STUDENT TRAVEL/FIELD TRIP INFORMATION and PARENT CONSENT FORM

AUG 09 2016

Group/Team: CEHS Model UN (World Affairs Council) # Students attending: 20
 Faculty Leader Name(s): Melissa Oliver # of Chaperones: 2
(including Ldr)

Trip Destination: Providence, Rhode Island

Trip Date(s): 11/11/16 - 11/13/16

Anticipated Departure Time: 9:00 a.m. Anticipated Return Time: 6:00 p.m.

Transportation by: CEHS Bus Transportation

Driver(s) (if other than school /commercial carrier): _____

In An Emergency, How Can Trip Leader(s) Be Contacted: cell: (603) _____ / moliver@capeelizabethschools.org

FOR OVERNIGHT TRIPS:

Accommodations: Physical address, phone _____

Provisions for Mixed Gender Supervision: yes

PRE-TRIP PARENT MEETING (for Trip involving Three (3) or More Overnights) WILL BE:

Date: 11/03/16 Location: CEHS Room 201 Time: 7:30 a.m.

PARENT CONSENT FORM for STUDENT TRAVEL/ FIELD TRIP

Group/Team:	CEHS Model UN (World Affairs Council)
Staff Ldr:	Melissa Oliver
Trip name:	Providence, Rhode Island

PARENT / STUDENT CONSENT

I hereby give my permission for _____ (son/daughter's name) to participate in the travel/field trip(s) named and described herewith. 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. I understand that it is my responsibility to obtain health insurance coverage for medical expenses that may occur.

_____ Parent Signature	_____ Student Signature (if 18 or older)
_____ Date	_____ Date

EMERGENCY CONTACT AND MEDICAL INFORMATION FORM

Student Name: _____ DOB: _____

Health Insurance Provider:	Plan/Certificate #:
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1st Contact: _____ Relationship: _____
 Work Home Cell
 Phone: _____ Phone: _____ Phone: _____

2nd Contact: _____ Relationship: _____
 Work Home Cell
 Phone: _____ Phone: _____ Phone: _____

Non-Parent Contact: _____ Relationship: _____
 Work Home Cell
 Phone: _____ Phone: _____ Phone: _____

Known Allergies? If yes, provide treatment protocols below:

Medication or Treatment Restrictions:

Medication(s) that student will be bringing for self-administration: