Frost M.S. Music Department
Chicago Tour 2023 Field Trip Packet

Student First and Last Name:

____

Class: Check the class you're in

____ 1- Concert Band

____ 2- Symphonic Band

____ 4- Chamber Orchestra

____ 5- Concert Orchestra

____ 6- Guitar Fundamentals

Online registration must be completed by November 10, 2022: No late submissions after.

Fill out the entire packet, and turn in to Mr. Rais by November, 12, 2022

Do not bend this packet: A new one will need to be filled out again.

Livonia Public Schools

Do not Bend

Parent/Legal Guardian Permission

For Participation in Field Trip

School Name: Frost M.S.

Teacher: M. Rais

Permission Slip Due By: 11/20/22

I, the parent/legal guardian of X ______ (the student),
(child's full name)
give my permission for the student to fully participate in the following school-sponsored field trip:

Date of Trip: April 21 - April 22, 2023 Time of Trip: Fri. 8:00 Am - Sat/Sun 12 Am

Destination: Chicago, Il / VanderCook College of music

Reason for Trip: Performance/Clinic

MODE OF TRANSPORTATION:

Livonia School Bus ☐ Private Vehicle ☐ Walking ☐

Commercial Bus ☒ ______ Other specify: ______
(Name of Carrier)

ADMISSION:

☐ There is no fee for this field trip.

☐ This field trip is partially funded by PTA.

☐ To cover the cost of admission, we would appreciate a donation of: ______

☐ Cash ☐ Please make checks payable to ______
(school name)

Bagged lunch required ☐ Yes ☐ No

Phone number where the parent/legal guardian can be reached during the field trip: ______

Medical information of which the teachers/chaperons should be aware and medications* needed by the student while on the field trip X Fill out medical Form

*Medication authorization form must be on file in the school office.

I understand that the student is not required to participate in this field trip, that it is not part of the student's required curriculum, and that should I decline to sign and return this form; the School District will provide an alternative educational experience for the student for the duration of the field trip.

I understand that during this field trip, the student is expected to follow all school rules, and will cooperate with, and follow the directions of, the teachers, chaperons, and bus drivers.

I agree to hold the Livonia Public Schools, and its employees, and agents, harmless from all damages, costs, and attorney fees incurred as a result of any injury or damages caused by the student during the course of this field trip.

X ______ X ______
Signature of Parent/Legal Guardian Date

FOR FIELD TRIP DRIVERS/CHAPERONES:

All Drivers and Chaperones must have a cleared ichat form on file with LPS

I will agree to drive/chaperone students' to ______
(place)

and return on ______
(date)

☐ I have a cleared ichat form on file with LPS.

☐ I am a properly licensed driver.

☐ I will have all passengers and the driver use seatbelts.

☐ I have the appropriate liability insurance as required by the State of Michigan.

Signature: ______ Phone Number: ______
(That you can be reached while on the trip)

Address: ______

Teacher: ______ Date: ______

Behavior Contract
Frost Middle School / Chicago Tour 2023

By signing this you agree that you will be following Frost Middle School Handbook Rules and Regulations when attending the Chicago Tour 2023 field trip on Friday, April 21 2023 - Saturday, April 22 2023. As a student of Frost Middle School, you are representing our school and school district. Frost MS and Green Light Tours are not responsible for any personal items that are lost or stolen at the event on: 4/21/23 - 4/22/23. Any behavior that violates Frost MS rules will result in immediate contact to parent/guardian and consequences will be handled at school on Monday April 24, 2023.

Please return this with your registration form.

____ **Date:** _________
Student Name (Printed)

____ **Date:** __________
Student Signature

____ **Date:** __________
Parent or Guardian Signature

Phone Number that parent/guardian can be reached at during field trip:
(______)_________-___________________

Everyone must fill out this form.

Medical Release Form

Parent/Legal Guardian's Name: ______________________

Address: ______________________

Phone #s: Home (_____) _____-_______

Work (_____) _____-_______

Cell (_____) _____-_______

Other (_____) _____-_______

Children's Names	List all Known Medical Conditions, Including Food Allergies and/or Drug Allergies. In Addition, Include Any and All Over-the-Counter and/or Prescription Drugs Taken Regularly.

In an emergency, please contact: ______________________

Relationship to child/children: ______________________

Phone #s: (_____) _____-_______ (_____) _____-_______

(_____) _____-_______ (_____) _____-_______

Or contact: ______________________

Relationship to child/children: ______________________

Phone #s: (_____) _____-_______ (_____) _____-_______

(_____) _____-_______ (_____) _____-_______

Physician's Name: ______________________

Address: ______________________

Phone #s: (_____) _____-_______ (_____) _____-_______

Dentist's Name: ______________________

Address: ______________________

Phone #s: (_____) _____-_______ (_____) _____-_______

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Medication Authorization

Student's Name ______________________ Date ______________

Date of Birth ______________________ School ______________

Teacher / Counselor ______________________ Grade ______________

Both prescription and nonprescription medications require a completed Medication Authorization form signed by a physician and parent/guardian. If medication is related to a life-threatening health condition, Livonia Public Schools staff will develop an Individualized Health Care Plan in conjunction with the student's physician.

TO BE COMPLETED BY THE PHYSICIAN

Name of Medication ______________________ ☐ Prescription ☐ Non-Prescription

Reason for Medication ______________________

Form of Treatment ☐ Tablet / Capsule ☐ Inhaler ☐ Liquid ☐ Injection ☐ Nebulizer

Instructions ______________________

Dosage ______________________

Time of Day ☐ Daily ☐ As Needed ☐ Emergency Only ☐ Other - ______________

If dosage is "as needed" or "emergency only" specify symptoms and limits: ______________

Relevant Side Effects ______________________

Storage Requirements ☐ None ☐ Refrigerate ☐ Other - ______________

Student is capable and responsible for self-possession and self-administering: ☐ Inhaler ☐ Emergency Meds

Please indicate if you have provided additional information: ☐ On the back of this form ☐ As an attachment

Physician's Name ______________________ Phone ______________

Address ______________________ Fax ______________

____

______________________ ______________
Physician's Signature Date

TO BE COMPLETED BY THE PARENT / GUARDIAN

I request that ______________________ (Student's Name)

☐ receive the above medication at school according to district policy.

☐ be allowed to self-administer the above medication (inhaler or emergency medication) at school according to district policy.

☐ I authorize school personnel to contact the above physician with questions or concerns relative to this authorization and medication.

______________________ ______________
Parent / Guardian's Signature Date

NOTES

1. Medication includes prescription, non-prescription and herbal medications, and includes those taken by mouth, by inhaler, those that are injectable, and those applied as drops to eyes, nose, or medications applied to the skin.
2. Medications must be in an appropriately labeled container.
3. This authorization is valid for the current school year only.
4. This authorization must be maintained with the Individual Student Medication Log.
5. It will be the student's responsibility to make contact with school personnel for the administration of medication, unless other arrangements have been made by the administrator.