RESPONSIBILITY CONTRACT FOR OVERNIGHT TRIPS

It is a privilege for you to participate in the District-sponsored trip to _____. Because this trip is part of the District's educational program, it is imperative that you adhere to the Code of Conduct for overnight trips as well as the applicable provisions of the general Code of Conduct. You must remember that from the time of departure to your arrival home, you are the responsibility of the District.

I agree to:

A. refrain at all times from the consumption of alcoholic beverages and/or drugs unless said drugs are prescribed by a physician and dispensed by school personnel or self-medication and/or possession are properly authorized;

B. sleep in my assigned room and not entertain members of the opposite sex in my room, unless my room door is fully opened, and an adult chaperone is notified;

C. keep my assigned chaperone advised of my whereabouts at all times;

D. attend all mandatory activities and meal functions;

E. adhere to all established curfews;

F. conduct myself in such a manner as to bring pride to myself, my family, my school, and my community;

G. adhere to any established dress code;

H. comply, throughout the trip, with any and all instructions directed to me and/or the group by a chaperone or staff member.

If a problem arises that is serious enough in nature to warrant the below-named student's removal from the travel group, we (the student and parent/guardian) agree to bear any additional costs to return the student home. NOTE: This removal decision will be made by the accompanying professional staff member after a student has been provided the opportunity to respond to any allegations. The student may also be subjected to discipline upon return home in accordance with general District policies.

_____ _____

Student Date

_____ _____

Parent Date

CUYAHOGA VALLEY CAREER CENTER
8001 Brecksville Road * Brecksville, Ohio 44141
(440) 526-5200

PARENTAL PERMISSION FORM FOR FIELD TRIP

Personal Information		
I hereby give permission for my child to attend a field trip as scheduled by their CVCC instructor. I understand that my child is being chaperoned and every precaution is being made to prevent accidents. I will not hold Cuyahoga Valley Career Center or the organization sponsoring the trip responsible for anything that may occur in connection with this trip. I also understand that if my child violates CVCC's code of conduct consequences will be issued. If this is an overnight trip and violations occur parents may be required to either come to pick up their student or student will be sent home COD.		
Student's Name		
Student's Cell Phone #	( )	
Parent/Guardian's Signature		
Parent/Guardian's Phone # Cell Phone#	( )	**Date**

Emergency—In case of an emergency, please contact me or the person listed below.		
Emergency Contact Person		
Emergency Contact Phone #	( )	

Field Trip Details	
CVCC Program Name	
Place of Field Trip	
Date of Field Trip	
Departure Time	
Returning Time	

Transportation	(Check One)
School Van	
School Bus	
Chartered Bus	
Public Transportation	
Other Phone #	( )

Please be aware that all school rules are in effect while on a school sponsored trip. Should a student violate any of the rules students are subject to discipline and will not be allowed to participate in the above mentioned activity. Parents will be contacted and may be required to pick up their child or arrange transportation from the location of the above designated destination. Given reasonable suspicion, any travel and/or personal effects are subject to our search and seizure policy #5771. Students may need to make arrangements for transportation home from the associate school. Please contact your associate school for more information.

AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Address _____

School _____ Grade _____

A. I am requesting permission for my child named above to: (Check all that apply)

_____ use or receive prescribed medication

_____ receive prescribed treatment

_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member

in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent _____ Date _____

Home Telephone _____ Work Telephone _____

PHYSICIAN STATEMENT

To the Physician:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

Name of Student _____ Address _____

School _____ Class/Grade _____

I have prescribed the following medication _____

Beginning Date _____ Ending Date _____

Dosage, instructions, or precautions: _____

Report the following side effects to my office immediately _____

Physician's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

_____

_____

_____
Director

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT
(SECONDARY VERSION)

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Address

_____ _____
School Class/Grade

A. I am requesting permission for my child named above to: (Check one or both)

[ ] use or receive the following over-the-counter medication(s).

Medication: _____

Dosage: _____

Check Option 1 or 2 below.

[ ] self-administer such medication(s) in the presence of an authorized staff member.

[ ] keep the medication(s) in his/her possession and self-administer the medication(s) as needed.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatment(s):

_____

_____

_____
Director