



James Ries, Principal  
Lisa Moorer, Assistant Principal  
Jillian Carter, Dean of Students

Dear Parents/Guardians:

The seventh grade will be traveling to Cedar Point on **Monday, May 13, 2024**. The cost of the trip is **\$90.00** per child (if a student already has a season pass, the cost is \$54.00) which includes: all day admission to the park, round trip bus transportation, and a lunch voucher. Cell phones and extra money can be brought if needed; however, students are responsible for their belongings. If your student has a season pass to Cedar Point or **will not** be attending the Cedar Point trip, please email [ddagostino@twinsburgcsd.org](mailto:ddagostino@twinsburgcsd.org) so that the price can be adjusted for the trip.

**Students should report to school as NORMAL and will be leaving for the day by 8:30 a.m. Students must be picked up from RBC promptly at 6:30 p.m.**

Attached to this letter are the necessary forms: permission slip, medical data, emergency treatment, and conditions of the trip. Please note that students also need a medication authorization form (attached) completed by a doctor if medication will be administered the day of the trip. If your child already has medication on file in the clinic at RBC, you don't need to fill out another medication authorization form.

**All Payments must be made online through Payschools. No payments will be accepted at school. Collection of permission slips, medical forms, will take place April 3 & 4, 2024 in the cafeteria during the students lunch period. Also, if a student has any outstanding fees, he/she will not be permitted to attend the trip until fees are paid. The payment deadline for Cedar Point is April 5, 2024.**

RBC teachers will chaperone a majority of the groups; however, we may need parent volunteers to chaperone as well. If you are interested, please return the slip below. Once all paperwork is submitted and groups are formed, parents will be contacted (early May) if they are needed to chaperone.

Per RBC's field trip and discipline policy, students who have accumulated 20 points as a result of referrals, and/or suspensions for violations of rules in the Student Code of Conduct, are not eligible to attend the trip. Discipline points are ongoing and accumulated up to the day of the trip. The school dress code, as well as all school rules, applies on any and all field trips.

If you have any questions, please email:  
[lfontana@twinsburgcsd.org](mailto:lfontana@twinsburgcsd.org) (yellow team leader)  
[awilson@twinsburgcsd.org](mailto:awilson@twinsburgcsd.org) (red team leader)

Sincerely,  
7<sup>th</sup> Grade Team Coordinators

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**\*I am available to *potentially* be a chaperone for Cedar Point\***

**Parent Name:** \_\_\_\_\_ **Child's Name:** \_\_\_\_\_

**Phone Number and/or email:** \_\_\_\_\_

TWINSBURG CITY SCHOOL DISTRICT  
R.B. CHAMBERLIN MIDDLE SCHOOL  
TWINSBURG, OHIO

**PARENTAL PERMISSION SLIP: 7<sup>TH</sup> GRADE CEDAR POINT TRIP**

**Students will be traveling by bus to Cedar Point Amusement Park, in Sandusky, Ohio on Monday May 13, 2024.  
Students will be leaving school at approximately 8:30 am and returning at 6:30 pm.**

Dear Parents: Your child is eligible for participation in an educational trip described below. The following form is divided into four sections which: (1.) identify your child and the trip for which he/she is eligible (2.) provide pertinent medical data (3.) establish a procedure for emergency treatment (4.) set forth the conditions and limitations upon Board liability in connection with your child's participation. Please read the forms carefully. No child will be permitted to participate in the trip unless full payment and forms are submitted promptly with necessary data and signatures.

(1.) Student's Name \_\_\_\_\_

	Last	First	Initial
Student's Address _____	Street	City	Zip Code

**(2.) MEDICAL DATA:**

Is this your child's first trip away from home without parents? \_\_\_ Yes \_\_\_ No

Is your child allergic to any drugs or foods? \_\_\_ Yes \_\_\_ No

If yes, which drugs/food: \_\_\_\_\_

Is your child allergic to Tylenol? \_\_\_ Yes \_\_\_ No

Is your child allergic to bee stings? \_\_\_ Yes \_\_\_ No

If yes, what is the bee sting procedure: \_\_\_\_\_

Is your child susceptible to motion sickness? \_\_\_ Yes \_\_\_ No

If yes, please state what treatment, if any, you request: \_\_\_\_\_

Date of last Tetanus shot? \_\_\_\_\_

Does your child have any medical conditions of which the school personnel should be aware? (Example: heart condition, diabetes, seizures, recent injuries, asthma, allergies or illnesses). \_\_\_ Yes \_\_\_ No

If yes, please describe specifically: \_\_\_\_\_

**In the event medication is to be administered by school personnel, the parent must personally deliver an adequate supply of the medicine directly to the school prior to the departure. Also in accordance with the Twinsburg District Procedure, Code JHCD, Section R: YOU MUST SUPPLY WRITTEN PERMISSION AND DIRECTIONS FOR ADMINISTERING SAID MEDICINE BY HAVING THE PHYSICIAN AND THE PARENT COMPLETE THE STUDENT MEDICATION AUTHORIZATION FORM (see attached).**

Is your child currently taking any medication, prescription or over-the-counter, (including Tylenol, Benadryl, cold medication, etc.) which he/she will be taking during the trip? \_\_\_ Yes \_\_\_ No

If yes, please list: \_\_\_\_\_

Do you have medical insurance that covers your child? \_\_\_ Yes \_\_\_ No

If yes insurance company: \_\_\_\_\_ Policy or Contract Number: \_\_\_\_\_

Any other information regarding your child's health that you feel the staff should be aware of? \_\_\_ Yes \_\_\_ No

If yes, please list: \_\_\_\_\_

**(3.) EMERGENCY TREATMENT:** In the event that my child should become ill or injured during the course of this educational trip, I request that you make reasonable attempts to contact the following:

Mother's or Guardian's Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's or Guardian's Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

(Other) Emergency Contact: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If attempts to contact the above have been unsuccessful, I hereby give my consent for : (1) The administration of any treatment deemed necessary by a licensed physician, and (2) The transfer of the child to a hospital or any emergency facility as deemed necessary by school personnel and/or physician.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

**(4.) CONDITIONS AND LIMITATIONS in connection with this educational trip:**

a. It is understood and agreed that portions of this trip may be rescheduled, postponed, or canceled due to strikes, sickness, quarantine, government restrictions or regulations, acts of God, or acts of omissions of, or damaged or malfunctioning property owned by any service or transportation company, firm, individual or agency, and that either the Board of Education of the Twinsburg City School District, its members, officers, employees, group leaders, nor chaperones shall be held responsible therefore.

b. It is expressly understood and agreed that the child and parents assume the risk of harm, injury, or loss which the child may incur during the course of this trip. This waiver and release including but not limited to, risks arising while the student is on "Free Time" and while the student is absent from the group for other reasons authorized by the parent in writing in advance.

c. It is further understood and agreed that the child shall comply with all rules and regulations of the Board of Education, including suggestions, recommendations, rules and regulations of chaperones and staff members, in all matters pertaining to the program or personal contact and that failure to do so shall be grounds for immediate termination of the child from the trip and his/her being returned home at the parents' expense, without refund of any other trip fees.

**I have read, understand, and accept all of the above-stated conditions.**

\_\_\_\_\_  
PARENT/Guardian

\_\_\_\_\_  
CHILD/STUDENT



<input type="checkbox"/> Twinsburg High School	330.486.2400	<input type="checkbox"/> Samuel Bissell Elementary School	330.486.2100
<input type="checkbox"/> RB Chamberlin Middle School	330.486.2281	<input type="checkbox"/> Wilcox Primary School	330.486.2030
<input type="checkbox"/> George G. Dodge Intermediate School	330.486.2200		

Please attach  
a picture of  
the student

### EXTENDED FIELD TRIP MEDICATION ADMINISTRATION FORM

<b>Student Name:</b>	<b>Date of Birth:</b>
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I request and give consent to a volunteer chaperone/teacher/nurse that has been authorized by the Twinsburg City School District, to administer the medication(s) listed below to my child. **I will provide medication in accordance with the Twinsburg City School District's Field Trip Medication Policy #5330.** I further agree to hold harmless the Board of Education, all school employees, and volunteers from any and all liability for damages or injury caused by the administration; of medication to my child.

I have **provided** the following **prescribed Daily medication(s)** listed below and my student should receive them on the extended field trip only. This authorization will be revoked upon completion of the trip. ***(Please note that a medical practitioner's signature IS required if prescriptive medication will be administered to your child during the trip.)***

Medication	Dose	Time to Administer	Purpose of Medication

Medical Practitioner's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Medical Practitioner's Name (Printed) \_\_\_\_\_ Phone: \_\_\_\_\_

I have **provided** the following **over-the-counter medications**, and my signature authorizes administration to my child in the event she/he experiences symptoms listed.

This authorization will be revoked upon completion of the trip. I further agree to hold harmless the Board of Education, all school employees and volunteers from any and all liability for damages or injury caused by the administration of medication to my child. ***(Please note that a medical practitioner's signature is NOT required for the administration of NON-prescriptive medications.)***

Medication Brand	Dosage	Administer	Purpose of Medication

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (Printed) \_\_\_\_\_ Phone: \_\_\_\_\_



Check this box if your child currently has medication in the school clinic and are requesting that we utilize that medication for the field trip. (i.e. EpiPen). Please note that this form must be completed in its entirety according to the Field Trip Medication Policy.