**OLD ROCHESTER REGIONAL JUNIOR HIGH SCHOOL SURVIVAL PROGRAM Mattapoisett, MA 02739**

Dear Parent/Guardian:

Your child has been selected to participate as a chaperone in the Survival Program. The steps to full acceptance require students to: 1) participate in a full week of the program, 2) attend the Leadership Training and all staff meeting on June 8 after school, 3) attend post-trip equipment cleaning and re-shelving activities, 4) conduct themselves in a responsible way for the duration of the school year as a representative of the Survival program

It is necessary that we have, for our records, information essential for your child's best interest as he/she participates in the weeklong program away from home. Consequently, we ask that you complete this form and have your son/daughter return it on as soon as possible to Ms. Wheeler at the Junior High or High School.

Medical problems are referred to the Baystate Franklin Medical Center, Greenfield, MA 1-413-773-0211 (main switchboard), 1-413-773-2263 (ER). Competent medical personnel will handle all lesser ailments on site. \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

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Name of Student Date of Birth

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Street of Address Town Zip

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Parent/Guardian Name Phone # Emergency Contact Name Emergency #

Indicate insurance plan you have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SIGNATURE OF PARENT OR GUARDIAN DATE

"The undersigned is the parent or lawful guardian of the herein named student and hereby consents to his/her participation in the ORR Junior High Wilderness Experience. I expressly agree to hold harmless the members of ORR District School Committee, its servants, all chaperones, or other persons associated with ORR Junior High School Wilderness Experience from responsibility by reason of my son's/daughter's participation in said experience.

I hereby authorize such medical and/or surgical services, including the administration of anesthesia as may be recommended or ordered by a qualified physician or surgeon, to be rendered to and upon my son/daughter, and further to authorize emergency treatment by first aid personnel for the treatment of any injury or illness occurring or manifesting itself while my son/daughter is engaged in this experience."

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SIGNATURE OF PARENT OR GUARDIAN DATE

It is of utmost importance that we are provided with current and accurate medical information. This is not an appropriate time to withhold medical information for reasons of privacy, etc. All information will remain strictly confidential. If your son/daughter has any (even minor) medical problems or is on daily medication, which may require some sort of treatment or special consideration, please explain below. (severe reactions to insect strings, severe food allergies, knee, ankle, or back problems are especially pertinent.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_