



Dear Parents of RoboForce Club Members,

We are excited to be going to the FIRST Mid Atlantic Robotics Competition on March 10<sup>th</sup> and 11<sup>th</sup> at the Westtown School!

Each student needs to turn in the field trip permission slip to attend. Parents need to sign the permission slip (no teacher signatures required - this is a weekend event)! **THEY ARE DUE BY MARCH 1<sup>st</sup>**. Keep this flyer to put on your fridge!!!

Your son/daughter will need to meet us in the rear parking lot of the school each day at the following times!

	Saturday	Sunday
Behind school at	6:00 a.m.	6:00 a.m.
Back at high school	8:00 p.m.	7:00 p.m.

(may return earlier, it depends on what needs to get done)

A small group of students will go to set up the pit and get the robot inspected after school on Friday March 9<sup>th</sup>.

Every student who rides to the competition with us is expected to ride home with us. In the past we have held up the group looking for students who went home with their parents. If you wish to take your child home you **MUST** come in and speak face to face with **Ben Preddy** or **Sarkis Berberian** on that day in order to have your student released to you.

The competitions are free and open to the public. We hope that you will be able to come see us compete. The competitions are always very exciting. **The students should bring money to buy breakfast, lunch, and plenty of snacks each day.**

Thank you for your support,

Sarkis Berberian      610-996-6243 (cell)

Ben Preddy            484-764-7400 (cell)

**Westtown School  
975 Westtown Road  
West Chester, PA 19382 USA**

Please fill out completely

FIELD TRIP PERMISSION FORM

I. SPONSORING TEACHER INFORMATION Date 2-27-17

X

\_\_\_\_\_ is seeking permission to go on a field trip.  
 Name of Student  
WESTOWN SCHOOL on SUN MAR 11 from 6:00 AM (SAT)  
 Destination Day and Date Dismissal from class  
 to 8:00 PM supervision of BEN PREDDY. Transportation to be  
 Arrival time Teacher's name  
 provided by Haverford in the form of school vans, mentors & parents  
 School District (specify) Van/Bus/Other Cars

\*\*Special considerations (cost, lunch, proper attire, etc.

Emergency Contact Arrangements

\*\*\* Any special medical conditions, complete reverse side of form

bring \$ for breakfast, lunch, snacks

II. STUDENT RESPONSIBILITY

The student has the responsibility to have this form completed and returned to the sponsor/teacher at least 1 week prior to the trip date. This form must be returned to the sponsor/teacher no later than MARCH 1. If you fail to do so, you will not be

Due Date

permitted to attend the trip. **STUDENTS ARE RESPONSIBLE FOR ANY WORK MISSED AND ARE TO SEE TEACHERS TO MAKE ARRANGEMENTS.**

III. TEACHER INFORMATION

Teachers whose classes are to be missed must sign below using a full last name. Your signature does not signify permission, but indicates that you have been notified of this trip.

\*\*A in the parenthesis below indicates that the teacher has concern about this student missing his/her classes.

X Block 1 \_\_\_\_\_ ( )

X Homeroom \_\_\_\_\_ ( ) Students are not to be marked absent on the day of the trip.

\* Block 2 \_\_\_\_\_ ( )

X Block 3 \_\_\_\_\_ ( )

X Block 4 \_\_\_\_\_ ( )

IV. Parent's Approval - Please read carefully. \_\_\_\_\_ X  
Parent Signature

Please fill out other side →



Please fill out completely

School of District of Haverford Township  
Haverford High School;  
200 Mill Road - Havertown, Pennsylvania 19083 610.853.5900.2001/2527  
**STUDENT MEDICAL AUTHORIZATION**  
(trips overnight and greater than fifty miles)

I \_\_\_\_\_ hereby grant permission for the properly designated school personnel to have emergency care rendered to my child \_\_\_\_\_ He/she is under their supervision/care.

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone/Cell \_\_\_\_\_

Work Phone \_\_\_\_\_

Medical Insurance (Name & Numbers) \_\_\_\_\_

Personal Physician Phone# \_\_\_\_\_

Relative or friend who may be contacted (two)

Name \_\_\_\_\_ Name \_\_\_\_\_

Relation \_\_\_\_\_ Relation \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Medical History (Fill in the blanks where applicable)

Allergies (including medications) \_\_\_\_\_

Epilepsy \_\_\_\_\_ Diabetes \_\_\_\_\_

Bee Sting \_\_\_\_\_ Other \_\_\_\_\_

Daily Medication (Name and Frequency) \_\_\_\_\_

I assume financial responsibility for any medical bills. I further release the school district and its representatives from responsibility for any problems that might be incurred as a result of medical care and or treatment.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

please fill out other side →