



8th Grade Field Trip to Islands of Adventure and Universal Studios

- **When?** Friday, May 16th 2025; 1:00 pm to 2:30 am (times are approximate)
- **Who can attend?** Any MMS 8th grader who has NOT received OSS or more than 2 days of ISS starting October 1, 2024.
 - Students must have regular **attendance**.
 - Students must be **passing all subjects** at 3rd quarter report card and on track to pass for the year.
- **Payment?** The total cost of the trip is \$ 230.00 per student
 - Payment is due by Thursday February 13th
 - You can pay by **cash** or **check** payable to Murray Middle School
 - Price includes charter bus transportation, t-shirt, admission to both parks, and a meal!
 - Season Passes are **not** accepted for this special event...sorry!

Final Payment Deadline: Thursday, February 13, 2025

Refunds must be requested in writing by 3/24/2025

******There will be no refunds for any reason (including removal from trip due to discipline) after this date

Trip Guidelines

- Students must **always** remain with their **partner** while in the park.
- Students are required to **check in** with teachers at 8:00 PM. We will be departing the park at 12 AM.
- As part of Universal's **dress code** requirements, all students attending the trip must wear the same t-shirt.
- Students are responsible for all items brought on the bus (electronics, money, etc). Be aware that no phones are allowed on the roller coasters, but lockers are available.

**Any questions? Contact Ms. Brailsford at
dawn.brailsfordmoretta@stjohns.k12.fl.us
We are looking forward to a great trip!**

Student Name	First Period Teacher
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I UNDERSTAND THE REQUIREMENTS FOR ME TO ATTEND GRADVENTURE

- 1) Students must NOT have received any days of OSS and no more than 2 days of ISS starting October 1st.
- 2) Students must have regular **attendance**
- 3) Students must be **passing all subjects** at 3rd Quarter Report Card and on track to pass for the year

I UNDERSTAND THE DRESS CODE

- 1) Wear the Gradventure t-shirt. DO NOT cut, rip, or modify your shirt.
- 2) Make sure to get the correct size t-shirt. There are no returns after they are ordered.
- 3) Wear appropriate clothing – NO short shorts, rips, tears, bathing suits

I UNDERSTAND THE PAYMENT DEADLINES

- 1) The **deadline** for turning in the permission slip and payment is **2/13/2025**
- 2) Space on the bus is **limited** and the trip may be at capacity before that date.
- 3) NO refunds after **3/24/2025** for any reason including removal from trip due to discipline.

- I would like to help a student-in-need. I have enclosed a donation of \$_____
- ⇒ Donations must be made with cash or a **separate** check. **Don't include it with your child's payment.**

- I have enclosed Cash or Check payment of \$230.
- ⇒ Checks must include name, **physical address**, and **phone number**.
- ⇒ Write **student name** on memo line of check

- I have enclosed Cash or Check payment of \$_____
- ⇒ Partial payments are accepted with **full amount due** by February 13th

Shirt Size (circle one)	Adult Regular Fit						
	XS	S	M	L	XL	2XL	3XL

PLEASE RETURN ALL FORMS AND PAYMENTS TO MS. BRAILSFORD

**St. Johns County School District
Parent Permission Form for Field Study Activities**

School: R.J. Murray Middle School

I/We, the parents/guardians of the student named below, have been informed of the activities planned for the field study to: (If visiting multiple locations, list all.)

BrAdventure at Universal Orlando on May 16, 2025
(DATE)

Time to Leave: 1 PM Return: 2:30 AM Anticipated Number of Chaperones 12

This field study includes a supervised water activity: Yes _____ No X

charter bus at a cost of \$ 230.00
(Mode of Transportation)

We understand in times of national emergency or any other time when it is in the best interest of the health, safety and welfare of students and employees, the School Board may revoke its approval assuming no liability for reimbursement of costs or expenses incurred by the cancellation of any activity.

I/We hereby grant permission and give my/our consent for my student to (1) be treated by any qualified nurse, physician, or surgeon as may be deemed necessary by the District, its agents, servants, or employees during the activity; (2) be administered medication and/or emergency first aid care as may be necessary or appropriate; and (3) receive treatment in hospitals, medical offices, or elsewhere in the event of accident or illness. To assist in that medical care or treatment, I/we represent that the medical information supplied on the Medical Information Form is true and accurate. The District, its agents, servants, or employees are not responsible for acts or omissions of third parties as a result of securing medical care. I/We will hold the District and its agents, servants, or employees harmless and indemnify them from any claim, cause of action or demand arising out of any form of or the lack of medical or emergency treatment rendered to my student.

In the event that a student must return to school independently for reasons of health, accident, failure to conform to rules established by the teacher in charge, etc., we agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses. This permission slip also serves as a contract that the student and parent(s) understand and agree to the guidelines from each teacher as to making up missed assignments.

My student requires medication and/or non-emergent medical attention: YES _____ NO _____ *on back

If yes, you must complete the Medical Information Form (obtained from the activity supervisor) and provide an Authorization to Assist in the Administration of Medication/Treatment form signed by both the parent/guardian and the physician ordering the medication, if not already on file in the school clinic.

_____ Signature of Parent/Guardian		_____ Date
_____ Cell Phone	_____ Work Phone	_____ Home Phone
_____ Emergency contact if parent is unavailable		_____ Phone
_____ Family Physician		_____ Phone
_____ Health Insurance Provider		_____ Policy#

Medical Information Form

✶ (Required for any student requiring medication or medical attention) *✶*

Student's Name: _____ Date of Birth: _____

Health Insurance Provider and Medical Plan # _____

Parent/Guardian's Name: _____ Contact Number(s): _____

Doctor's Name & Phone Number: _____

Emergency Contact Name & Phone Number: _____

List any ailments, disabilities or problems involving your child which may affect her/her participation.

Allergies (Food) _____ Allergies (Seasonal) _____

Asthma _____ Diabetes _____

Epilepsy _____ Other _____

Information sponsors should be aware of:

1. Unusual reactions or allergies to medication? _____

2. Special care needed while on activity? _____

3. Special instructions to medical personnel if emergency care is needed? _____

4. Significant health problems? _____

An employee trained to administer medication must accompany students needing prescribed medication during field study hours. All medications (prescription and over-the-counter) must have an Authorization to Assist in the Administration of Medication/Treatment form signed by both the parent/guardian and the physician ordering the medication, if not already on file in the school clinic. All medications must be received in the original container with the current Rx label including student's name, dosage, frequency of administration, physician's name and expiration date of the medication (the expiration date on the pharmacy label, not on the medication box, will be the expiration date). Over-the-counter medications must be in the original, unopened container. EXCEPTION: Students at the middle and high school level may carry a non-prescription, non-emergency medication on his/her person while in school with written permission from the parent/guardian. A copy of the signed permission form must accompany the stated medication at all times.

Name and purpose of medication: _____

How it will be given: _____ Time to be given: _____

Parent/guardian's signature: _____

IN CASE OF EMERGENCY: I hereby request the physician/emergency team selected by the activity supervisor provide treatment for my child named above.

Parent/guardian's signature: _____

Date: _____