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*	Senior Checklist	*
会	There is a second of the secon	*
会	Please use this checklist to ensure that you have completed the necessary tasks for Senior Day and Graduation.	会
会	Read this entire packet	会
会	Ordered a cap, gown, and tassel package via Herff Jones (pick up from Mrs. Weaver in Room 222)	会
会	Have a senior portrait on file with the yearbook (done through Lifetouch) OR have emailed Mrs. Weaver a senior portrait to be used in the graduation slideshow (only if you did <u>NOT</u> have one taken by Lifetouch)	*
公	Field trip form for the Salem Red Sox <u>signed and returned</u> to your GOVERNMENT TEACHER OR	会
公	MRS. WEAVER IN ROOM 222 – due by Friday, April 5th.	会
*	Made your senior poster (can be turned in to the front office starting April 8th)	会
会		会
*		*
*	Senior Day Bus Assignment Survey	会
*	Please go to the link below to complete the very short, one question survey regarding	会
*	which elementary school you would like to visit on our Senior Day field trip.  Please complete this no later than Friday, April 5th.	*
*	If you do not complete this survey, a bus will be assigned to you at random.	*
*		公公
*	http://tinyurl.com/HVClassof2024	分
*		*
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*		*
*		*
*	****	1

## FIELD TRIP INFORMATION GRADES PK – 12

School HVHS		Date3/22/24
Class or group:	HVHS Senior	Class
Destination:	Salem Red Sox	stadium
Departure:	Time: 10am	Date: 4/22/24
Return:	Time: 1.15pm	Date: 4/22/24
Type of transportation:	School Bus	
Total charges/student:	S R	
Type of supervision:	Members of school staff	
your permission and releas return it to the school along	se from liability are required. Please with the appropriate fee by THIS DAT erning this activity, please do not hesital	
<b>,</b>		
Salem Red	Sox Stadium	_ has my permission to go on the field trip to _ on <u> </u>
surgical or dental diagnosis healthcare practitioner as a resulting expenses will be to the little important that all familiation that the school administration while this would indeed be occur, the money paid for the in advance. Therefore, the	s or treatment and hospital care from deemed necessary for the student's she responsibility of the parent/guardianties understand that, should conditions tion believes the trip be unsafe in trace unfortunate for all involved, we mushe trip will not be refunded. Most of the	ever x-ray, examination, anesthetic, medical, a licensed dentist, physician, surgeon and/or safety and welfare. It is understood that the n and not the Roanoke County School Board. In our country at the time of the trip be such evel or destination, the trip will be cancelled. It is make safety our first priority. Should this ne costs associated with the trip must be paid refund. We will make every effort to recoupsued.
Parent/Guardian Signatur	e:	Date:

Please complete the reverse side of this form and return to your child's school.

\*Must complete back\*-

## FIELD TRIP GRADES PK-12 HEALTH INFORMATION

(Please print all information)						
Name		Age	Date	e of birth		
Address		8			e e	
City State	y State Zip code Telephone no					
Names of custodial parents/legal guard	dians					
Mother's/female legal guardian's work	phone number		Mobile no			
Father's/male legal guardian's work ph		Mobile no				
Alternate contact name and phone num				no		
List any medical conditions/allergies, o				ware:		
Date of last tetanus shot:			Caland Insurance: TVos TNo			
Insurance: If yes, company name _		policy no:				
	PAREN	T PERMISSION	a			
I give permission for designated directions for an allergic reaction.			e		s □ No	
I give permission for my child to prescribed. Prescription medication	receive the medi ns require a docto	cation(s) listed below or/healthcare provide	w as needed a r's signature be	elow.	s 🔲 No	
I agree to provide the school with p be limited to inhalers, epi-pens, glu	rescribed emerge	ency medicine which	may include b  Not App	ut not Yes	s □ No	
Parent signature:			Dat	te:	P #	
	MEDICATIO	N ADMINISTRATIO	N	500 ALDEADY	ON FILE	
**PHYSICIAN SIGNATURE IS REQUAT THE SCHOOL. The parent must for each one.	UIRED BELOW FO provide medication	OR PRESCRIPTION Mass in the original conta	liner and comple	ete the following in	iormation	
Name of Medication	Dosage	Time to Admini	ster Da	ate/Time Administered	/Initials	
100						
			/			
			• /			
If more space is needed, use addition				to		
**Physician signature (Rx Med on (Required If not on file at school)	ly):		Da	te:		