

Westlake Middle School

West Lake Drive
Thornwood, NY 10594

November 10, 2025

Dear Parents/Guardians of 7th Grade Students,

We are happy to announce our trip to Broadway to see *The Outsiders* on **Wednesday, February 11, 2026**. Students read the book by S. E. Hinton in ELA class this fall, and we are excited to offer this amazing follow-up experience for our seventh-grade students!

- **Location:** Bernard B Jacobs Theatre, 242 West 45 Street, New York, NY, 10036
- **Departure:** 11:30 AM after eating lunch on school grounds.
- **Showtime:** 2 PM - (runtime is 2h 30 mins)
- **Estimated Return Time:** 7:00 PM (Must be picked up at the school upon arrival)
- **Clothing:** Students should dress in seasonal, school-appropriate attire.
- **What to Bring:** Students should bring a bagged lunch and snacks to be consumed before leaving. Lunch will be eaten at an alternate time, so students will not have access to the cafeteria. Outside food and beverages are not permitted in the theater, but can be left on the bus during showtime.
- **No refunds will be given once the tickets are purchased.**

The cost of attending the trip is **\$85**. If your child will be attending, please fill out the permission slip on the attached page and return it to school, along with a **check payable to MPCSD**, by **Wednesday, November 19th, 2025**. Students must hand in their signed permission form and payment to the main office.

Please sign and return all shaded parts of this form by **Wednesday, November 12th, 2025.**

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I. NEW YORK STATE NO-FAULT LAW PERTAINING TO SCHOOL BUSES:

There are special rules for occupants of a school bus and no-fault insurance coverage, then the insurer of the school bus provides no-fault benefits. This law, therefore, requires passengers to first apply claim to their own automobile insurance carrier. The School District has been advised that this does not impact individual residents' car insurance rates, but represents a cooperative program by all insurance companies to address this insurance matter.

I hereby consent that my child _____ is permitted to take this class trip going by a chartered or regularly licensed omnibus. I am willing that he/she makes this trip as a class member to **The Outsiders on Broadway on 2/11/26.**

In order for my child to participate in this trip, I acknowledge and agree to the above stated guidelines.

PARENT/GUARDIAN SIGNATURE/DATE _____

II. EMERGENCY AUTHORIZATION:

In the event of a medical emergency, and I cannot be reached, I hereby give permission to a licensed health care provider at a medical facility to provide proper medical treatment.

PARENT/GUARDIAN SIGNATURE/DATE _____

III. EMERGENCY CONTACT INFORMATION:

In case of an emergency during this field trip, I can be contacted at the following number(s):

HOME: _____

CELL: _____

ALT. CELL: _____

PARENT/GUARDIAN SIGNATURE/DATE _____

TRIP MEDICATION AUTHORIZATION

A. AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS

NOTE: Authorization for medications **MUST** be completed in order for your child to have **ANY** medications while on the trip, including any **OVER-THE-COUNTER** medications (i.e., **TYLENOL, ADVIL, etc.**) and **you MUST provide a physician's order for any medication listed below**

(PART B). Any changes to your child's medication after completing this form and prior to the trip must be shared with our school nurse, Cheryl Horowitz, (914) 769-8540, x2700.

Must be completed by Parent/Guardian

My Child _____ has my permission to have the following medication(s) during the class trip. My child has been instructed in the proper use of the medications listed below.

My child may self-administer medication **with a private physician's order (Must Complete Authorization Below, Part B)**

Adult supervision is required and may be given by a nurse or a WMS chaperone. (Medication must be held by the nurse and **Part B must be completed**)

MEDICATIONS	DOSAGES	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: _____

PARENT/GUARDIAN SIGNATURE:

B. AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS

MUST BE COMPLETED BY LICENSED PRESCRIBER (Physician's order can be attached)

Name of Licensed Prescriber (please print):

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____