Dear Parent or Guardian,

Your child is attending the EOSA Science Weekend. Please read the information on this form, then sign and return it to your child’s SMILE teacher by ________________.

Yes, I give permission for ________________________________ to attend the SMILE Elementary Outdoor Science Adventure Weekend at the University of Rhode Island’s Alton Jones campus in West Greenwich, RI on ____________.

_________________________ ______________________
Parent/Guardian Signature           Date

Departure:
We will leave from ________________________________ Elementary School on Friday, April 5, 2019 by bus at ____________.

Return:
Students will be picked up from ________________________________ Elementary School by a parent or guardian on Saturday, April 6, 2019 at approximately ____________.

Students are to bring their sleeping bags and packed bag of clothes to school the morning of April 5th.

Sincerely,
SMILE Teachers
**ELEMENTARY**

**EXPECTATIONS**

I. Electronics

➢ **CELL PHONES**
  - If a cell phone is brought to the EOSA Weekend, text messaging and phone calling is **not** allowed during activities, unless given permission by your SMILE teacher. If a cell phone is seen in use without permission, it will be taken and returned at the end of the event.

➢ **OTHER ELECTRONICS**
  - **Only** cameras are allowed for “other electronics”. Please leave all tablets/iPads/iPods etc., at home. If they are brought to Alton Jones, they will be taken by teachers/staff and returned at the end of the event.

**The SMILE Program is not responsible for any lost belongings.**

II. Meals

When at the Environmental Ed. Center for meals, students must sit in sight of the URI mentors.

III. Cabin Time

Students need to be **respectful and quiet** at bedtime, so that everyone can get a good night’s rest. Students will be sleeping in same-gender cabins with at least two adults (with certified background checks) supervising. If a student is unable to comply with the cabin expectations, SMILE staff will call the person whose name appears below, so that he/she can get picked up and taken home.

III: Emergency Contact Information

Name and phone number of person to contact if student needs to be picked up from the Alton Jones Campus:

Name: ___________________________________ Relation to student: __________________________

Best Phone Number to be reached at any time: ____________________________________________

Student Name (Print): _______________________________________________________________

Student Signature: ___________________________ Date: __________________

Parent/Guardian Name (Print): _________________________________________________________

Parent/Guardian Signature: ___________________________ Date: __________________
The University of Rhode Island SMILE Program
Medication Policy and Medication/Prescription Authorization
Elementary Outdoor Science Adventure (EOSA)
April 5-6, 2019

Students needing medication during the EOSA are required to bring the medication with a signed authorization. Both prescription and non-prescription medications require parent authorization.

Prescription medications shall be stored in their original pharmacy labeled containers. Non-prescription medication shall be stored in their manufacturer-labeled container only.

No student shall have in his/her possession any medication. (See exceptions Re: inhalers and EpiPens®)

All medications shall be dispensed by the EOSA nurse. This does not include inhalers, which may be self-administered if authorized by licensed health care provider, or EpiPens® which may be self-administered, or administered by trained personnel or, in the event that no trained personnel are available, any willing person may administer the EpiPen® to a medically identified student.

NO MEDICATION SHALL BE DISPENSED WITHOUT FOLLOWING THIS PROCEDURE

The following is to be completed by the PARENT or Legal Guardian.

School________________________________________________Grade__________

Student’s Name ________________________________________ Sex_____ Date of Birth_________________

Physician’s Name/Address:__________________________________Physician’s Phone:__________________

I request that my child be assisted in taking the medicine(s) described below at the EOSA by the nurse. This medication(s) will be sent in on the day of the event. (If the procedure is not followed, the student will not be allowed to self-medicate)

Name of Medication_____________________________________________________________

Dose/Time_____________________________________________________________________

Reason(s) for medication__________________________________________________________

Length of time this treatment is recommended_________________________________________

Allergies_______________________________________________________________________

Other information_______________________________________________________

__________________________________   _________________________________
Parent/Guardian signature      Date

__________________________________   _________________________________
Home Phone       Emergency Phone