EXPECTATIONS FOR ROWERS

&

RULES FOR OVERNIGHT FIELD TRIPS

This trip is a privilege, not a right.

Coaches, Parents, and your teammates have all worked hard to get ready for this Regatta. Coaches are in charge of the team at the water. Chaperones are in charge when you're at the WSHS Tent (riverside), hotel, bus, bowling alley, and during any free time. The Chaperones are volunteers and parents of your teammates. Please be respectful of them when they need to enforce rules, give correcting comments, or administer consequences.

RULES

1. Proper behavior will be expected at all times. Rowers are required to abide by all rules contained in the Fairfax County Public Schools Student Rights and Responsibilities. This includes all regulations regarding the use of tobacco, alcohol, and drugs, language, dress code, etc. You are representing WSHS and Spartan Crew, as well as yourself. Be courteous and considerate to everyone at all times. Listen to your chaperones and abide by his/her guidance. Use appropriate, respectful language. NO PROFANITY!
2. Rowers may not leave the hotel or regatta site without an adult chaperone.
3. BUS RULES

- No sharing of blankets
- Use respectful language. No profanity
- Keep noise at a level safe for the driver
- No standing for extended periods of time
- Do not throw objects - even in fun - this is a safety hazard
- Clean around your seat before departing the bus and deposit trash in the bag located at the front of the bus
- Always double-check to ensure you have all your belongings before departing the bus

4. HOTEL RULES

- Rowers are not permitted to change room assignments.
- Please do not play music at a loud volume, run, or shout in public areas (hallways, lobby, elevators) of the hotel. Be respectful of all Hotel guests.
- No profanity.
- Do not leave your hotel room unless fully clothed. Dress appropriately for the occasion. It is improper to wear pajamas or bed clothes in the hallway (unless it's a fire alarm)
- Rowers are only allowed on the floors where we have rooms for our team
- Rowers of the opposite sex MAY NOT enter each other's rooms under any circumstances.
- At curfew, each rower must be in his or her assigned room.
    - BE ON TIME!
    - After lights out, please be quiet so as not to disturb others.
    - Doors are to remain closed and locked.
    - Chaperones will check on their students' rooms periodically.
- Do not leave valuables or money in rooms. Talk to your chaperones about where to put these items.
- Rooms should be left just as when you arrived. Report any problems in your room to your chaperone immediately.

5. Rowers are responsible for knowing when and where to meet chaperones and buses. The time will be announced each time you leave the bus, ALWAYS BE ON TIME.

6. Remember the Buddy System! Never roam around alone. Exchange phone numbers with your chaperone and always reply to his/her text or call.

7. No public displays of affection. This is a school field trip, not a date.

8. Always respect the property of others.

Clothing should fit, be neat and clean, and conform to standards of safety, good taste, and decency. When wearing the Spartan Crew Uniform, do not remove the top portion, no matter how hot the temperature.

9. Do not take inappropriate pictures or videos of anyone at any time during the trip.

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PARENTAL AUTHORIZATION AND ACKNOWLEDGEMENT OF RISK FOR FIELD TRIP

(This form and an attached itinerary description are required for all field trips.)

1

IMPORTANT DIRECTIONS: (1) Use one form per trip, (2) Complete the school portion (top half) of form, (3) Duplicate one form per student, and (4) Send a copy home for parent and student signatures.

TO BE COMPLETED BY THE SCHOOL

Date(s) of Trip	Destination
May 14 -16, 2026	**Philadelphia, PA**

Purpose

Attend the Stotesbury Cup Regatta, hosted by the Schuykill Navy

FCPS stock medications, to include (Epinephrine, Albuterol, and Naloxone) will not be provided on this field trip.

SUPERVISION (Check one.)

☐ Students will be directly supervised by adults on this trip at all times

☒ Students will be directly supervised by adults on this trip with the following exceptions:

free time between races; while at river between spectator tent and boat launch; between curfew and breakfast while sleeping

TRANSPORTATION BEING PROVIDED (Check all that apply.)

☐ Walking ☐ School Bus ☒ Commercial Carrier ☐ Personal Vehicle

☐ Leased Vehicle ☐ County Vehicle ☐ None

DRIVERS OF PRIVATE OR LEASED VEHICLES (Check all that apply.)

☐ Student ☐ Parent ☐ Teacher or Staff Member ☐ Other Adult

VEHICLE TYPE (Check all that apply.)

☐ Car ☐ Van (10 passenger or less) ☐ SUV ☐ Other _____ *(Specify)*

RISK RELATED (Check all that apply.)

☐ Swimming Pool ☐ Amusement or Theme Park ☐ Beach or Ocean ☒ Other Water Related Activity *(List activity)*

TO BE COMPLETED AT HOME

Pupil Agreement

While participating in this trip, I will accept responsibility for maintaining good conduct and appearance, and I will follow directions at all times.

_____ _____

Signature of Student Date

PARENTAL AUTHORIZATION AND ACKNOWLEDGEMENT OF RISKS

I understand that participation in this trip is voluntary, that it is not required, and that it exposes my child to some risk(s). I also understand that the trip may include amusement activities and that participation in any amusement activities will expose my child to some risk of injury or even death. I have read and understand the itinerary and authorize my child to participate in the planned components of the trip to the extent indicated by my signature below. I also understand that participation in the trip will involve activities off school property; therefore, neither the Fairfax County School Board, or its employees and volunteers, will have any responsibility for the condition or use of any nonschool property.

PARENT PERMISSION (Check all that apply.)

☐ Participation in all aspects of this trip.

☐ Participation in all aspects of this trip, except the amusement and theme park activities.

☐ Participation in all aspects of this trip, except the water-related activities.

☐ Other _____

I give permission for _____ to participate in this field trip.

_____ _____

Signature of Parent Date

IMPORTANT NOTICE Fairfax County Public Schools (FCPS) cannot be responsible for reimbursements to parents or students of money submitted as advance payment (e.g., for Broadway shows, transportation, or hotels) for any trip **that FCPS cancels. It is strongly recommended that you personally review any tour company's or commercial carrier's contract, including its stated refund policies, BEFORE your child signs up or pays for the trip.**

Fairfax County PUBLIC SCHOOLS
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FIELD TRIP LUGGAGE SEARCH

2

No student will be allowed to participate in the school activity scheduled for departure on May 14 , 20 26 , unless PART I or PART II is completed and signed by a parent or guardian.

PART I
CONSENT TO SEARCH

I, _____ , give my consent to officials of Fairfax County Public
Print Parent's or Guardian's Name
Schools and their officially designated representatives to search the luggage of my child, _____ , in connection with the school activity scheduled
Print Student's Name
for the above date. Also, I give my consent for any search, deemed advisable, of my child's lodgings while on the trip.

_____ _____
Parent's or Guardian's Signature Date

PART II
CERTIFICATION OF CONTENTS AND DELIVERY OF LUGGAGE

I, _____, certify that I will search and deliver the luggage of my
Print Parent's or Guardian's Name
child, _____ , and it will not contain any illegal or prohibited items.
Print Student's Name
Also, I give my consent for any search, deemed advisable, of my child's lodgings including luggage, while on the trip.

_____ _____
Parent's or Guardian's Signature Date

Fairfax County PUBLIC SCHOOLS
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MEDICATION AUTHORIZATION

Release and Indemnification Agreement

3

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE **PLEASE USE A SEPARATE FORM FOR EACH MEDICATION**

PART I PARENT OR GUARDIAN TO COMPLETE

I hereby authorize Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless FCPS, FCHD, SACC, and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided FCPS, FCHD, and SACC staff members comply with the licensed prescriber, parent or guardian orders set forth in accordance with the provision of Part II below. **I have read the procedures outlined on the back of this form and assume responsibility as required.**

Has the student taken this medication before? ☐ Yes ☐ No (If no, the first full dose must be given at home to ensure that the student does not have a negative reaction.)
First dose was given: Date _____ Time _____

Student Name: Last	First	Middle

Date of Birth	School Name	School Year	Grade

No School Board employee, public health nurse (PHN), licensed practical nurse (LPN), or school health aide shall administer medication or treatment, as an exception under School Board policy, unless the principal or his or her designee has personally reviewed all the required clearances. I give permission for the Public Health Nurse (PHN) to contact the below named licensed prescriber to clarify information provided on the order should the need arise.

Parent or Guardian Signature _____ Daytime Telephone _____ Date _____

PART II PARENT OR GUARDIAN TO COMPLETE AND SIGN FOR OVER-THE-COUNTER MEDICATION PER MANUFACTURER'S RECOMMENDATION FOR RELIEF OF SYMPTOMS FOR HEADACHE, MUSCLE ACHE, ORTHODONTIC PAIN, OR MENSTRUAL CRAMPS FOR THE ENTIRE SCHOOL YEAR. OVER-THE-COUNTER MEDICATIONS FOR SYMPTOMS OTHER THAN HEADACHE, MUSCLE ACHES, MENSTRUAL CRAMPS, ORTHODONIC PAIN, INCLUDING ANTIBIOTICS, AND ANTIVIRAL MEDICATIONS MAY BE GIVEN FOR TEN CONSECUTIVE SCHOOLDAYS WITH ONLY THE PARENT OR GUARDIAN'S SIGNATURE. LICENSED PRESCRIBER MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS.

The Fairfax County Health Department and Fairfax County Public Schools discourage the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and overnight field trips and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

Diagnosis

Medication	Route (Oral, Injection, Inhalation, Topical, Buccal, Rectal, etc.)

If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time between doses.

Dosage to be given at school or SACC, (e.g. mg, ml)	Time(s) or interval between doses

Effective Date: _____
☐ Current School Year **OR** ☐ From _____ To _____

If the student is taking more than one medication for the same symptom(s), list sequence in which medications are to be taken: _____

Licensed Prescriber Name (Print or Type) _____ Licensed Prescriber Signature _____ Telephone or Fax _____ Date _____

Parent or Guardian Name (Print or Type) (Not required if licensed prescriber signs) _____ Parent or Guardian Signature _____ Telephone _____ Date _____

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate:

☐ Parts I & II above are complete including signatures. (It is acceptable if all items in Part II are written on the licensed prescriber's stationery or a prescription pad.)

☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be PICKED UP by the parent or guardian. (Within one week after expiration of this authorization or on the last day of school.)

Principal or Principal Designee Signature _____ Date _____ Student ID _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

PARENT/GUARDIAN INFORMATION ABOUT MEDICATION PROCEDURES

1. **The first dose of any new medication must be given at home with the exception for a rescue medication.** Medications should be taken at home whenever possible so that the student will not lose valuable classroom time or have a shortened lunch period.

2. The parent or guardian must provide FCPS and SACC a supply of medication to be administered during the school day and in SACC. Only a 30-day supply of medication should be brought into school at a time. **The parent or guardian must transport medications to and from school, except a high school student may carry an over-the-counter medication to and from the school health room.**

3. Any medication taken in school or SACC must have a parent or guardian-signed authorization; some medications also require licensed prescriber's orders. No medication will be accepted by school or SACC personnel without receipt of completed and appropriate medication forms. If parent or guardian requests to pause a medication with a licensed prescriber's order, it requires a letter from the licensed prescriber or a new authorization to restart the medication.

4. A licensed prescriber may use office stationery or a prescription pad in lieu of completing Part II. Include the following information written in English lay language with no abbreviations:
   - Name of student
   - Date of birth
   - Reason for medication or diagnosis
   - Name of medication
   - Exact dosage to be taken in school (e.g., mg, ml)
   - Route of administration
   - Time to take medication and frequency or exact time interval dosage is to be administered
   - Sequence in which the medications should be taken in cases where more than one medication is prescribed - If medication is given on an as-needed basis, specify the exact conditions or symptoms when medication is to be taken and the time at which it may be given again. (“Repeat as necessary” is unacceptable.)
   - Duration or effective dates of medication order
   - Licensed prescriber's signature and date

5. All prescription medications, including licensed prescriber's prescription drug samples, **must** be in their original containers and labeled by a licensed prescriber or pharmacist in English. The pharmacy label must match the authorization. Non-prescription medication should always be kept in the **original, unopened bottle or box** with the name of the medication visible and no more than 100 pills/tablets/capsules. The following information must be included on the OTC label for the original container:
   - Name of student
   - Route of administration
   - Exact dosage to be taken in school (e.g., mg, ml)
   - Frequency or time interval dosage is to be administered

6. The parent or guardian is responsible for submitting a new form to the school and to SACC at the start of the school year and each time there is a change in the dosage or in the time at which medication is to be taken. If parent or guardian requests to pause a medication, it must be in writing and a new medication authorization form needs to be completed.

7. Medication must be kept in the school health room or other school-approved location during the school day.

8. Medication kept in the school will be stored in a locked area accessible only to authorized personnel.

9. The student is to come to the school health room, or to a predetermined location, at the prescribed time to receive medication. Parent or guardian should develop a plan with the student to ensure that the student goes to the school health room at the appropriate time. **Medication can be given no more than one half hour before or after the prescribed time.**

10. The Fairfax County Health Department, Fairfax County Public Schools, and Fairfax County School Age Child Care do not assume responsibility for authorized medication taken independently by the student.

11. In no case may any health, school, or SACC staff member administer any medication outside the framework of the procedures outlined here and/or in FCPS regulations.

12. Within one week after expiration of this authorization, discontinuation of medication or on the last day of school, the parent or guardian must pick up any unused portion of the medication. Medications not claimed within that period will be destroyed.

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MEDICATION AUTHORIZATION

Release and Indemnification Agreement

4a

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE **PLEASE USE A SEPARATE FORM FOR EACH MEDICATION**

PART I PARENT OR GUARDIAN TO COMPLETE

I hereby authorize Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless FCPS, FCHD, SACC, and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided FCPS, FCHD, and SACC staff members comply with the licensed prescriber, parent or guardian orders set forth in accordance with the provision of Part II below. **I have read the procedures outlined on the back of this form and assume responsibility as required.**

Has the student taken this medication before? ☒ Yes ☐ No (If no, the first full dose must be given at home to ensure that the student does not have a negative reaction.)
First dose was given: Date _____ Time _____

Student Name: Last	First	Middle

Date of Birth	School Name	School Year	Grade
	West Springfield High School	25-26	

No School Board employee, public health nurse (PHN), licensed practical nurse (LPN), or school health aide shall administer medication or treatment, as an exception under School Board policy, unless the principal or his or her designee has personally reviewed all the required clearances. I give permission for the Public Health Nurse (PHN) to contact the below named licensed prescriber to clarify information provided on the order should the need arise.

Parent or Guardian Signature _____ Daytime Telephone _____ Date _____

PART II PARENT OR GUARDIAN TO COMPLETE AND SIGN FOR OVER-THE-COUNTER MEDICATION PER MANUFACTURER'S RECOMMENDATION FOR RELIEF OF SYMPTOMS FOR HEADACHE, MUSCLE ACHE, ORTHODONTIC PAIN, OR MENSTRUAL CRAMPS FOR THE ENTIRE SCHOOL YEAR. OVER-THE-COUNTER MEDICATIONS FOR SYMPTOMS OTHER THAN HEADACHE, MUSCLE ACHES, MENSTRUAL CRAMPS, ORTHODONIC PAIN, INCLUDING ANTIBIOTICS, AND ANTIVIRAL MEDICATIONS MAY BE GIVEN FOR TEN CONSECUTIVE SCHOOLDAYS WITH ONLY THE PARENT OR GUARDIAN'S SIGNATURE. LICENSED PRESCRIBER MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS.

The Fairfax County Health Department and Fairfax County Public Schools discourage the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and overnight field trips and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

Diagnosis
Sunburn, Itching, Headache, Stomach Pain, Cramps, Muscle Pain

Medication	Route (Oral, Injection, Inhalation, Topical, Buccal, Rectal, etc.)
See Attached OTC Medications	Oral or Topical

If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time between doses.
Upon occurance of diagnosis

Dosage to be given at school or SACC, (e.g. mg, ml)	Time(s) or interval between doses
As directed on package	As directed on package

Effective Date: _____
☐ Current School Year **OR** ☒ From 5/14/2026 To 5/26/2026

If the student is taking more than one medication for the same symptom(s), list sequence in which medications are to be taken: _____

Licensed Prescriber Name (Print or Type)	Licensed Prescriber Signature	Telephone or Fax	Date
N/A			

Parent or Guardian Name (Print or Type) (Not required if licensed prescriber signs)	Parent or Guardian Signature	Telephone	Date

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate:

☐ Parts I & II above are complete including signatures. (It is acceptable if all items in Part II are written on the licensed prescriber's stationery or a prescription pad.)

☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be PICKED UP by the parent or guardian. (Within one week after expiration of this authorization or on the last day of school.)

Principal or Principal Designee Signature _____ Date _____ Student ID _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

West Springfield High School Crew

Supplemental Medication Authorization Form

4b

This form will only be used in conjunction with a completed and signed FCPS Medication Authorization form. If a signed FCPS form is not on file, we cannot administer any medication to the student. To provide any over-the-counter medication to a student, BOTH the FCPS Medication Authorization form and this Supplemental Medication Authorization form must be signed.

I, _____, authorize previously designated members of the WSHS Spartan Crew and/or FCPS employees to administer the following over-the-counter medication as per package instructions for my child, _____ for ailments for which the medication is designed, for the duration of the Stotesbury Regatta Field Trip & SRAA Nationals Field Trip.

None of the medications will be given in a dosage that exceeds the recommended amount on the package.

- ☐ Advil
- ☐ Tylenol
- ☐ Midol
- ☐ Dramamine
- ☐ Benadryl
- ☐ Pepto Bismol
- ☐ Tums
- ☐ Neosporin
- ☐ Visine
- ☐ Saline (Contact Lenses)

I also consent to the following prescription medications and/or emergency treatment as per my written instructions provided on a separate Medication Authorization Form provided to WSHS Spartan Crew Team:

_____

_____

Parent/Guardian Signature:

_____