



Dear JCL Parents,

On **Sunday, September 21**, the Menlo JCL will embark on its own epic journey, our annual Progressive Supper. We will depart from the Menlo circle at **4:30 pm** and anticipate a **8:30 pm** return to the school. We will visit three different homes and dine on delectable cuisine at each of them. The cost for this event is a paltry **\$5** which you can pay in cash, check (made out to Menlo School), or at the Bookstore (write BS on the form). Not only do you get great food, drink, and transportation, but you will have the opportunity to enjoy the company of your fellow JCLers and get to know the Menlo Latin community. Please return your money and forms **to Mrs. Vasquez in A222** no later than **Tuesday, September 16**.

Here is the itinerary. Many thanks to the families who are hosting the dinner!

Appetizers:	The Paces [302 Selby Lane, Atherton (592-7045)]
Main Course:	The Baldwins [20 Smoke Tree Lane, Woodside (529-1973)]
Dessert:	The Costellos [1336 Cloud Ave, Menlo Park (752-6959)]

If you need to contact us in case of emergency during the event, please call Mrs. Vasquez' cell phone at (650) 888-2489.

Sincerely,

Ben Barantschik and Grace Costello
MJCL Consuls

I give my son or daughter _____ permission to drive to
and from the Progressive Supper on Sunday, September 21, 2014, from 4:30 pm to 8:30 pm. We
are aware that students may drive only siblings on a school trip.

Parent or Guardian Name



**Parent Permission and Waiver, Medical Release, Emergency
and Medical Information Form - Day**

EVENT: Latin Progressive Supper

LOCATION: 3 Homes in the area

DATES: 9/21/14

TRANSPORTATION: bus provided

CHAPERONES: Dobbie Vasquez and Peter Brodie

Student's Name _____ Birth date: _____ Grade: _____

Address _____ City _____ State _____ Zip _____

PERMISSION

My/our child has permission to participate in this day trip. I/we are aware of the activities involved and understand that they may entail conditions and risks different from those encountered on campus. I/we along with our child accept these conditions and risks.

MEDICAL EMERGENCY

Should a medical emergency arise, Menlo School will attempt to first contact the student's parent(s) or guardian. However, if that is not possible, I/we authorize Menlo School and its representatives to arrange and consent to emergency X-ray examination, anesthetic, medical and surgical diagnosis and treatment and hospital care for my/our child under supervision of and as deemed advisable by a physician; and to arrange and consent to X-ray examination, anesthetic, dental and oral surgical diagnosis and treatment for my/our child under the supervision of and as deemed advisable by a dentist.

MEDICAL INFORMATION

I/we hereby certify that the information entered in the Vital Health Record for my/our child on the Magnus Health System website is accurate, complete, and up to date. I/we understand that information from the Vital Health Record for my/our child may be used by Menlo School representatives and by health care providers, for example in a medical emergency, and that any inaccuracy or omission could result in harm to my/our child.

Parent initial here to confirm that the Vital Health Record is accurate, complete and current: _____

To update your child's medical information go to: www.magnushealth.com

WAIVER

I/we for myself/ourselves and on behalf of our child, waive and release Menlo School (including its trustees, administrators, faculty members, other employees, agents, and representatives) from any and all claims, causes of action, damages, and costs which I/we and/or my/our child have or may incur in the future arising from or relating to the day trip and related activities. This waiver and release encompasses any and all financial, physical and/or mental harm or damage which I/we and/or my/our child may suffer in the event of an accident or injury, including death, which may occur or be sustained as a result of or in connection with our child's participation in the day trip and/or related activities.

Signature of Parent or Guardian Date: _____

Signature of Parent or Guardian Date: _____

Signature of Participating Student Date: _____

OVER THE COUNTER MEDICATION

Please circle over the counter medication that we may give your child:

*Tylenol Advil Tums Imodium (anti-diarrhea) Dramamine (anti-motion)
Cough suppressant Sudafed (decongestant) Pepto-Bismol Benadryl (anti-histamine)*

PRESCRIPTION MEDICATION FOR

Upper School students will be responsible for transporting and dispensing his/her own prescription medication unless otherwise indicated and arranged in advance with the School Nurse..

Medications should be packaged in a pharmacy or manufacturer-labeled container and labeled with the student's name, the prescribing physician's name, the name of the medication, the dosage, and the time at which the medicine is to be taken.

Package only the amount of medication that will be needed for the event

Student's Name: _____

Physician's Name: _____ Phone: (____) _____

Medication	Symptoms Requiring Medication	Dosage	Frequency/Special Instructions

Side effects (reactions to food, other medications, etc.) _____

Other important information about medication: _____
