



UKIAH HIGH SCHOOL

MUSIC DEPARTMENT
VOCAL MUSIC

1000 LOW GAP ROAD · UKIAH, CA 95482-3470

PH: 707.472.5750

September 08, 2022

Parents and Students!

UHS Choirs will embark on a one-night camping trip, roughing it on the north coast in Fort Bragg! We will head to the Pomo Valley Tribe camp for an evening of fun, games, singing, skits and s'mores! This year, we are excited to invite the UHS Band along for our retreat and rehearsal time.

In this packet, you will find: the preliminary itinerary, what the trip does/does not include, grading policy, behavior expectations, and student contract.

In order to secure your student's spot on the field trip, please ensure that **ALL** of the following documents are filled out, signed and returned **no later than Friday, September 16, 2022**.

Document Check List:

- Field Trip Permission Slip
- Medical Treatment Authorization

Respectfully;

Joshua W. Small

Vocal Music Director
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Ukiah Vocal Music – UVM RETREAT

FRIDAY, SEPTEMBER 23, 2022

TIME	EVENT	LOCATION	DISTANCE
9:00am	Depart Ukiah High School	1000 Low Gap Rd., Ukiah, CA 95482	
11:00am	Arrive at Potter Valley Tribe Camp	21801 N HWY 1 Fort Bragg, CA 95437	58 miles
11:30am	Set up camp		
12:30pm	Gather in the common room (lunch)		
1:00pm	UVM Activities + Rehearsal		
5:00pm	Dinner & Activities with UHS Band		
7:00pm	Skit Rehearsal		
8:00pm	Skit Performances		
9:00pm	Karaoke / Movie Night / S'mores		

SATURDAY, SEPTEMBER 24, 2022

TIME	EVENT	LOCATION	DISTANCE
8:30am	Breakfast		
10:00am	Activities & Clean-Up		
10:30am	Depart Campsite for Fort Bragg Walk Around		
12:00pm	Lunch on your own		
1:30pm	Depart Fort Bragg for UHS		
3:00pm	Arrive at UHS for pick-up		

*All times are subject to change.

TRIP INCLUDES

1. Transportation by UUSD bus
2. Lunch and dinner on Friday
3. Breakfast on Saturday morning
4. Water

DOES NOT INCLUDE

1. Snacks – **BRING SNACKS/TREATS TO SHARE**

TRANSPORTATION

Students and chaperones will travel to the campsite and back via UUSD bus, with one vehicle tagging behind the bus. Exceptions will only be made for emergencies (medical or family).

CHAPERONES & PARENTS

This is a working retreat and time for the students to learn about themselves and one another, and how to sing in and work in a cohesive family unit. There will be at least two UUSD staff chaperones and two parents (male and female) for the entirety of the trip.

NEEDS

We will need tents, chairs and flashlights. If you have any, please let us know as we get closer!

BEHAVIORAL EXPECTATIONS

1. Be On Task
Whether you're packing your suitcase, cleaning up your room or getting ready to perform, know what to do, and do it. Adhere to deadlines, policies and instructions from your teacher/chaperone.
2. Do Your Best
Whatever you choose to do – ALWAYS do your best. We only get to perform our songs once and experience this trip once... Do your best to enjoy it and bring your "A" game.
3. Be Respectful
Excitement is not an excuse to act like a fool. Be respectful, courteous and responsible friends, classmates, students and human beings. Be the difference you want to see!

Any violation of these rules/expectations will result in severe disciplinary action.

UKIAH HIGH SCHOOL ACTIVITY/STUDY TRIP PERMISSION FORM

Ukiah High School 707.472.5785

SCHOOL **SCHOOL TELEPHONE #** **COUNSELOR**

STUDENT NAME **I.D. #** **GRADE** **TODAY'S DATE**

PURPOSE/EVENT Ukiah Vocal Music student retreat. Students will participate in rehearsal and activities over the course of the weekend.

LOCATION OF EVENT **ADDRESS/DIRECTIONS** **TELEPHONE NUMBER**

DATE 09/23 - 09/24 **TIME** 9am **TRANSPORTATION BY (CHECK ONE)** **BUS** **PRIVATE VEHICLE**

BASIC COST OF TRIP TO STUDENT **AMOUNT** **SACK LUNCH** **BRING SNACKS TO SHARE** **YES** **NO**

ADDITIONAL SPENDING MONEY FOR Lunch in Fort Bragg

NAME OF FACULTY CHAPERONE Joshua Small & Audrey McCombs
 (ADVISOR: YOU MUST TURN IN A LSIT OF STUDENTS ATTENDING TO THE ATTENDANCE OFFICE PRIOR TO DEPARTURE.)

CONTACT PERSON IN CASE OF EMERGENCIES: **JIM MOORHOUSE** 707-472-5081
 (DIRECTOR SUPPORT SERVICE) (OFFICE TELEPHONE)
HOLLY SEELEY 707-472-5091
 (TRANSPORTATION LEAD) (OFFICE TELEPHONE)

I HEREBY GIVE MY PERMISSION FOR _____ TO PARTICIPATE IN THE ABOVE ACTIVITY.

SIGNATURE OF PARENT OR GUARDIAN **PARENT/GUARDIAN TELEPHONE NUMBERS**
 (Parent or guardian must also complete and sign the second page of this form.)

TEACHERS:
 Students must request the signature of those teachers whose classes they intend to miss. The signature on the appropriate line below indicates their permission to miss their class. This should be done at a reasonable time before the event and at a time which will not interrupt the teacher.

PERIOD	TEACHERS' SIGNATURES
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR
AUTORIZACION DE CONSENTIMIENTO PARA TRATAMIENTO DE UN MENOR

(I) (We), the undersigned, parent(s) of _____, a minor, do hereby authorize _____ as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

(I) (We), hereby authorize any hospital which has provided treatment to the above-named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to (my) (our above-named agent(s) upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

(Yo) (Nosotros), los firmantes, padre/madre, padres de _____, un(a) menor, por la presente autorizo (autorizamos) a _____ como agente(s) para los firmantes para que den su consentimiento para cualquier examen de rayos X, anestesia, diagnóstico o tratamiento médico o de cirugía y cuidado de hospital que sea aconsejable por, y que ha de ser prestado bajo la supervisión general o especial de cualquier médico o cirujano autorizado bajo las provisiones del Estatuto del Ejercicio de la Medicina en el personal médico o en el hospital.

Se sobreentiende que esta autorización de cualquier diagnóstico específico, tratamiento o cuidado de hospital que sea necesario, se está haciendo para proveer autorización y poder de parte del agente(s) mencionado(s) para dar consentimiento específico para cualquier y todos dichos diagnósticos, tratamiento o cuidado de hospital que el doctor mencionado anteriormente, ejerciendo su mejor criterio crea conveniente.

Esta autorización es dada de acuerdo con las provisiones de la Sección 25.8 del Código Civil de California.

(Yo) (Nosotros), por este medio autorizamos a cualquier hospital que haya provisto tratamiento al menor mencionado arriba de acuerdo con las provisiones de la Sección 25.8 del Código Civil de California, entregar la custodia física de tal menor a (mi) (nuestro) agente(s) mencionado(s) arriba, cuando se haya completado el tratamiento. Esta autorización es dada de acuerdo a la Sección 1283 del Código de Salud y Seguridad de California.

These authorizations shall remain effective until/Esta autorización efectiva hasta _____, 20 ____, unless sooner revoked in writing delivered to said agent(s)/a menos que se revoque por escrito a dicho agente(s).

DATE/FECHA

PARENT OR GUARDIAN/PADRE O GUARDIAN

WITNESS/TESTIGO

Child's Birthdate/Fecha de Nacimiento del Niño(a): _____

Child's Doctor/Doctor del Niño(a): _____

Child's Dentist/Dentista del Niño(a): _____

Name and Number of medical Insurance Policy/Nombre y Número de la Póliza de Seguro Médico: _____

Chronic Illnesses/Enfermedades Crónicas: _____

Insured's Name/Nombre del Asegurado: _____

Medications (if long term)/Medicamentos (si usados por mucho tiempo): _____

Allergies/Alergias: _____

Last Tetanus/Ultima Vacuna para el Tétano: _____

THIS AUTHORIZATION IS VALID FOR ONE YEAR PAST DATE WRITTEN
ESTA AUTORIZACION ES VALIDA POR UN AÑO DESDE LA FECHA EN QUE FUE ESCRITA