

# *Rupert A. Nock Middle School*

70 Low Street, Newburyport, Massachusetts 01950

Tel.: 978-465-4447 • Fax: 978-465-4074

*Lisa Furlong, Principal • Nicholas Markos, Assistant Principal*

NEWBURYPORT PUBLIC SCHOOLS

March 2019

Dear parents of 6<sup>th</sup> grade students,

May is quickly approaching and it is time to prepare for our trip to Camp Kieve in Nobleboro, ME. We depart Newburyport on Wednesday, May 15 and return Friday, May 17. The goal of our leadership curriculum is to provide students with opportunities to practice leadership, goal setting, and decision making skills. The three-day camp experience is a fun and adventuresome culmination to this year-long initiative.

Attached is a packet of information and forms to be completed and returned to school. You will find consent and medical forms from both Camp Kieve and Newburyport Public Schools. If you have any questions about the forms, please contact Dawn DelTorchio in the main office ([ddeltorchio@newburyport.k12.ma.us](mailto:ddeltorchio@newburyport.k12.ma.us)).

We have also attached a list of supplies. Please remember that students do not need new luggage, sleeping bags, or clothing. If you need help with finding supplies, let us know!

Phones and electronic devices are not allowed at camp. Students have been told they may use an e-reader, ipod or other music playing device on the bus (no phones). These devices will be collected by the camp staff once we arrive. There are movies on the bus, so we are encouraging students to leave the electronics at home! Please do not send your child with his/her cell phone.

In addition, students are not allowed to bring food. If you have any medical concerns, please reach out to Christen Page our school nurse. For information on the camp lodging, menus, and logistics please visit the Kieve website: [www.kieve.org/leadership/](http://www.kieve.org/leadership/).

We are looking forward to another educational and exciting visit to beautiful Nobleboro, ME!

Warmly,

Lisa Furlong  
Principal

# Clothing/Equipment List: 6<sup>th</sup> Grade Camp Kieve ~ MAY 2019

**CLOTHING SHOULD BE MAINE WEATHER APPROPRIATE**

**It is NOT necessary to purchase new clothing, bedding or luggage**

**Please contact the school if you are in need of any of the items on the list.**

- Sleeping bag or 3 blankets & 2 sheets
  - Pillow
  - Clothing enough for the week, weather appropriate
  - Rain gear
  - Cold weather gear: hats, gloves, scarves
  - Boots/hiking shoes & extra sneakers (closed toe shoes)
  - Toiletry items – tooth paste, tooth brush, soap, shampoo, chapstick, deodorant, sunscreen, bug repellent (no aerosol)
  - 2 towels
  - Flashlight
  - Plenty of socks
  - White or light colored T shirt for tie dying (optional)
  - Heavy sweater/sweatshirt and Heavy jacket
  - Lightweight jacket or fleece
  - Camera (if you have one; disposable ones are great)
  - Water bottle (optional)
  - Stamped envelopes and writing paper
  - Laundry bag
- Ipods & e-readers are allowed on the bus rides to and from Kieve (NO PHONES)
  - Camp Staff will collect and store Electronic devices in a locked closet in your child's cabin
  - **ITEMS NOT ALLOWED:** cell phones, dvd players, jackknives, candy, gum, food

**ALL medications (over the counter, vitamins and Rx) must be in original container with only the amount for the 3 days, LABELED with your child's name and in a ziplock bag. ALL medications (over the counter, vitamins and Rx) must be checked in at school when the student is checked in on Wednesday morning. All medications will be available for PARENT pick up upon arrival at school on Friday afternoon.**

**PLEASE label your child's clothing and personal items (shoes, sneakers, boots, etc)**

**Address:**

**Camp Kieve**

**P. O. Box 169**

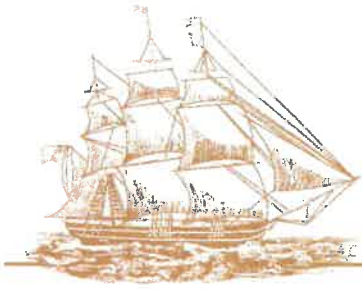
**Nobleboro, ME 04555**

**[www.kieve.org](http://www.kieve.org)**

**[leadershhschool@kieve.org](mailto:leadershhschool@kieve.org)**

**207-563-6212 Leadership School Office**

**207-563-6507 Residential Director**



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## KIEVE 3 DAY RESIDENTIAL PROGRAM AT KIEVE MAY 15 - 17, 2019 PERMISSION FORM

Student's Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_  
PLEASE PRINT

Parent/Guardian Signature: \_\_\_\_\_

Home Phone: \_\_\_\_\_ CELL Phone: \_\_\_\_\_

- I give permission for my child to participate in the *Kieve 3 Day Residential Program in Nobleboro, ME, May 15-17, 2019.*
- Please Return:  
All forms (6) from this packet and Kieve payment of \$275.00 (checks made payable to RAN Middle School) to the Nock Main Office By Friday ~ March 29, 2019. Thank you.
- Financial aid may be available for those students in need. Please check the appropriate box below to receive more information.
- Wednesday Morning Departure AND Friday Afternoon Arrival back at the Nock information will be in the Final Notice to Parents/Guardians to be sent home in May.

Please call Dawn DeTorchio @ 978-465-4447 ext. 2198 if you have any questions.

1. PLEASE CHECK THE APPROPRIATE BOX/ES
2. PLEASE RETURN THIS FORM TO NOCK MIDDLE SCHOOL MAIN OFFICE

- Enclosed is Payment in Full of: \$275.00       Enclosed are 6 forms
- Please send me Financial Assistance Information
- My child will NOT be attending Camp Kieve

### FOR OFFICE USE ONLY

Date Received: \_\_\_\_\_

Amount: \_\_\_\_\_  Cash    Check # \_\_\_\_\_  Money Order # \_\_\_\_\_

Balance Due: \_\_\_\_\_ Name on Check: \_\_\_\_\_



# The Leadership School at Kieve

Kieve-Wavus Education, Inc, PO Box 169, Nobleboro, Maine 04555  
Tel. 563-6212 Fax 563-5833

## Participant Information Form

Participant's Name \_\_\_\_\_ School or Organization RAN Middle School

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Sex - M F Age \_\_\_\_\_ Birth date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Does your child have any special needs (educational, behavioral, medical, or dietary) that we should be aware of or take any daily medication?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Parent/Guardian Authorization for Health Care:

This form is correct and accurately reflects the health status of the child. The child has permission to participate in all Kieve-Wavus activities except as noted by me and/or an examining physician. I authorize the Kieve-Wavus staff to provide routine healthcare, dispense medications, and seek emergency treatment for the child. I give permission to the physician selected by Kieve-Wavus to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the child. I understand the information on this form will be shared on a "need to know" basis with Kieve-Wavus staff. I give permission to photocopy this form. In addition Kieve-Wavus has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. Kieve-Wavus is not responsible for any medical costs incurred on behalf of the child.

I give permission to Kieve-Wavus to use my son's/daughters photo to publicize Kieve-Wavus programs.

\_\_\_\_\_  
Signature of Parent/Guardian

The medications listed below may be administered to your child on an as needed basis per Kieve-Wavus protocol and standing orders. If you wish your child to receive a medication that is not listed, including prescription medication, please complete the additional medication form. If you do not want your child to receive any of the listed medications, please indicate by drawing a line through the item with parent's initials next to the item.

- |                              |                                      |  |
|------------------------------|--------------------------------------|--|
| Acetaminophen(pain reliever) | Antacid (indigestion)                | Antibiotic Ointment (prevents skin infection)    |
| Benadryl (for allergies)     | Cough Drops (for cough/ sore throat) | Hydrocortisone 1% ointment (for skin itchinness) |
| Ibuprofen (pain reliever)    | Sunscreen                            |  |

Family Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Plan and Number \_\_\_\_\_



**NEWBURYPORT PUBLIC SCHOOLS**  
 70 LOW STREET  
 NEWBURYPORT, MASSACHUSETTS 01950-4096

*Office of the Superintendent*

TELEPHONE 978.465.4456  
 FAX 978.462.3495

**Parent Consent Form**

I hereby authorize my son/daughter/ward \_\_\_\_\_ to participate in \_\_\_\_\_  
 Grade 6 CAMP KIEVE PROGRAM  
 \_\_\_\_\_  
 NOBLEBORO, ME MAY

We the undersigned father and mother or guardian(s) of \_\_\_\_\_ a minor, do hereby consent to his/her participation in Gr. 6 Camp Kieve and do forever RELEASE, acquit, discharge, and covenant to hold harmless the City of Newburyport, a municipal corporation of the State of Massachusetts, and its successors, departments, officers, employees, servants, expenses and compensation on account of, or in any way growing out of directly or indirectly, all known personal injuries or property damages which we/I may now or hereafter have as the parent(s) or guardian(s) of said minor, and also all claims or right of action for damages which said minor has or hereafter may acquire either before or after he/she has reached his/her majority resulting or to result from his/her participation in the Newburyport Public Schools field trip programs: FURTHERMORE, we/I hereby agree to protect the City of Newburyport and its successors, departments, officers, employees, servants and agents, against any claims for damages, compensation or otherwise on the part of said minor growing out of or resulting from injury to said minor in connection with his/her participation in the Newburyport Public Schools field trip voluntary programs, and to INDEMNIFY, reimburse or make good to the City of Newburyport or its successors, departments, officers, employees, servants and agents any loss or damages or costs, including attorney's fees, the City or its representatives may have to pay if any litigation arises from said minors intentional, grossly negligent, or reckless acts or omissions while participating in said travel programs. When, for my son or daughter, the attending physician who is a member of the hospital recommends medical care and treatment, including minor surgical procedure, I give permission for the carrying out of such treatment.

Student Signature: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

**RUPERT A. NOCK MIDDLE SCHOOL**  
70 LOW STREET NEWBURYPORT, MASSACHUSETTS 01950  
(978) 465-4447 FAX (978)465-4074

**Parent, Insurance & Health Information**

**CHILD'S NAME:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_  
**TEL:** \_\_\_\_\_ **CELL:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**PARENT/GUARDIAN'S NAME:** \_\_\_\_\_  
**PARENT/GUARDIAN'S BUSINESS:** \_\_\_\_\_  
**TEL:** \_\_\_\_\_  
**EMERGENCY CONTACT:** \_\_\_\_\_ **TEL:** \_\_\_\_\_  
**FAMILY DOCTOR:** \_\_\_\_\_ **TEL:** \_\_\_\_\_

I understand that every effort will be made to contact parents or guardians of program participants. When, for my son or daughter, medical care, treatment, including a minor surgical procedure, and/or transportation to a local emergency room/hospital is recommended by the attending EMT and/or physician, I give my permission for the carrying out of such treatment and/or transportation.

**PLEASE INDICATE BELOW IF YOUR CHILD HAS ANY HEALTH/MEDICAL ISSUES OF WHICH WE SHOULD BE AWARE AND/OR ANY MEDICATIONS TAKEN ON A REGULAR BASIS.**

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE COMPLETE:**

Allergies requiring treatment: <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Insects <input type="checkbox"/> Other	
Allergy Name:	Reactions:
Treatment Plan:	

**Check Medical Conditions requiring treatment:**

- |   |   |   |                                      |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Diabetes    |
| <input type="checkbox"/> Seizures         | <input type="checkbox"/> Contacts/Glasses   | <input type="checkbox"/> Menstrual Issues   | <input type="checkbox"/> ADD/ADHD    |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Other _____ |

**Describe your child's symptoms and the treatment and/or medications required for the conditions you checked above.**


Father's signature: \_\_\_\_\_

Mother's signature: \_\_\_\_\_

Guardian's Signature (if applicable): \_\_\_\_\_

Blue Cross/Blue Shield Policy No: \_\_\_\_\_

Other Insurance: Company & Policy No: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

# Camp Kieve

## HOME AND HEALTH INFORMATION QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Date of Session: May 15 – 17, 2019

The questions below are provided to give you a framework within which to provide us any necessary information in regard to your child. Please feel free to add whatever information you think will be helpful—attach additional sheets if necessary. We will share this information with your child's classroom teachers prior to his/her arrival at camp

Thank you for your cooperation.

1. Is this your child's first prolonged stay away from home? \_\_\_\_\_
  
2. Is this your child's first sleep away experience? \_\_\_\_\_
  
3. Has your child ever had a problem with homesickness? If yes, please explain briefly.  
\_\_\_\_\_  
\_\_\_\_\_
  
4. Does your child have a bed wetting problem? \_\_\_\_\_
  
5. Are there any restrictions on your child's activities? Please include any special health concerns, e.g., special diet, recent hospitalizations, fractured bones, etc.  
\_\_\_\_\_  
\_\_\_\_\_
  
6. Has anything happened recently in your child's life that may affect him/her emotionally or physically while at camp? If yes, please explain.  
\_\_\_\_\_  
\_\_\_\_\_
  
7. Additional information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The Leadership School at Kieve**

Kieve-Wavus Education, Inc, PO Box 169 Nobleboro, Maine 04555  
 Tel. 563-6212 Fax 563-5833

**It is necessary for ALL parents/guardians to sign and return this form even if their child is not taking any medications.**

Participant Name: \_\_\_\_\_ School/Organization: Rupert A. Nock Middle School Newburyport, MA  
 Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_  
 Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ email: \_\_\_\_\_

**Medication Administration Form**

I give the nursing staff of The Rupert A. Nock Middle School and/or The Leadership School my permission to administer the following medications to my son/daughter.

- Acetaminophen  Ibuprofen  Antacid  Benadryl  Dramamine  Cough Drops  Antibiotic Ointment  Hydrocortisone Cream  Sunscreen

**Please complete the table for Prescription Medication or Over the Counter Medication that your child takes on a regular basis.**

Please check the appropriate box:  My Child does NOT take any medications at this time  My Child does take the medications listed below

Complete one row for each medication. Please send medication in original packaging clearly labeled with the participant's name and instructions. Please provide the appropriate amount for the duration of the participant's stay. (Please make additional copies of this form if necessary.)

Medication Name (Dose)	Time of Administration	M	T	W	TH	F	S	S
<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/> Other _____			For Staff Use					
<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/> Other _____			For Staff Use					
<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/> Other _____			For Staff Use					
<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/> Other _____			For Staff Use					