Hermitage R-IV Schools

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P.O. Box 327  302 East Polk Street  Hermitage, Missouri 65668 

Fax 417-745-6475



 **Krissy Friedman Ed Vest**

 Principal Superintendent

 417-745-6417 417-745-6418

Dear Parent/Guardian(s),

Because of the increased emphasis on ACT scores for college admission and scholarship opportunities, Hermitage High School students have a chance to attend an **ACT Prep Workshop at Osceola High School** on **Tuesday, October 21**. This is a great opportunity for high school students that are planning to take the ACT test in the near future. At this workshop, students will participate in sessions (with a focus on math and science testing, along with English and reading strategies) that will better prepare them for the ACT Test.

The cost of this workshop is **$20**, which covers workshop materials and lunch. Students must bring in a check or cash when you turn in your permission slip. Both payment and permission slip should be returned to Mrs. Shockley **before September 26** so we can register for the workshop. The bus will depart from school at 8:00 am and return by 3:00. Please let me know if you have any further questions.

Thank you,

Alana Shockley

School Counselor

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_request that my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_be permitted to participate in the ACT Prep Workshop at Osceola High School on Tuesday, October 21 from 8 am to 3 pm.

**MEDICAL RELEASE**

I understand that every effort will be made to contact me in the event of any accident or injury to my child, but in the event that I cannot be reached, I hereby authorize the school representative to consent to whatever medical or surgical treatment may be considered necessary or advisable by the physician or nurse in attendance and treating such injuries.

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 my agent to give specific consent for any and all such diagnosis, treatment or hospital care which the aforementioned physician or nurse in the exercise of his/her best judgment may deem advisable. This authorization is given pursuant to the applicable provisions of the Family Code of Missouri and the Health Code of Missouri.

**SIGNATURES**

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

Please print name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_