



OFF-CAMPUS SCHOOL ACTIVITY
PARENT CONSENT/LIABILITY WAIVER/MEDICAL RELEASE

- OVERNIGHT
OUT-OF-STATE
OUT-OF-COUNTY
OFF CAMPUS ONLY

Student: ID#: School:
Club/Group/Class: Supervising Faculty Member:
Activity: Location:
Departure Date: Time: Return Date: Time:
Method of Transportation:
School Bus Charter Bus Private Car School Vehicle Other
Parent will be responsible for getting the student to and from said activity
SWIMMING: WILL BE PERMITTED WILL NOT BE PERMITTED

Date of Birth: Ht: Wt: Date of your child's last tetanus shot:

Does your child have any of the following conditions?

- Epilepsy/Seizures Yes No Motion Sickness Yes No Diabetes Yes No Hemophilia/Bleeding Disorder Yes No
Any Medication Yes No Asthma/Wheezing Yes No Heart Disease Yes No Muscular/Skeletal problems Yes No

Any other condition which might possibly require treatment during the trip? Yes No

If yes, please specify:

Is your child currently being treated for any illness? Yes No If yes, please specify:

List any allergies to: Medicines Insects Foods Other

Are there any foods your child cannot eat? Yes No If yes, please specify what foods:

PARENT CONSENT/LIABILITY WAIVER/MEDICAL RELEASE

- I/We hereby give permission for my child to accompany employees of the Marion County School Board, acting as chaperones, to for the days indicated above. I/We will not hold the Marion County School Board nor their agents or employees accompanying the group responsible for any accident or injury to my child except as caused by the negligence of the School Board, its employees and agents.
In the event my child causes any property damage or personal injury, whether individually or in concert with other persons or entities, I/we agree to indemnify and hold harmless the Marion County School Board, its agents and employees.
I/We have read all the information in regards to this trip. I am aware of guidelines of said trip and the number of chaperones which will accompany my child.
I/We hereby grant permission to the attending physician or his consulting physicians, to render to my son/daughter any emergency treatment, medical or surgical care that might be deemed necessary to the health and well-being of said child. Also, when necessary for the administering of such care, I grant permission for hospitalization at an accredited hospital.
I/We assume full responsibility and liability for any and all expenses, damage, accident, illness, injury or medical expense of and to my/our child or our property resulting from such participation. I/We attest and affirm that the participant has no limitation that should prevent participation in the activity and I/we have not been advised or informed by anyone to the contrary.
I/We further agree to inform the appropriate school official(s) should my/our child's physical condition change in any way and any time so as to affect his/her participation in the activity herein named.

My student has medical insurance: Yes No Insurance Co: Policy#:

Home Telephone# Work Telephone# Pager/Cell Phone# Emergency Telephone#

Parent/Guardian Name (Print) Parent/Guardian (Signature) Date Home Address/City/Zip

THIS SECTION MUST BE COMPLETED BY PARENT ONLY IF STUDENT IS GOING OUT-OF-STATE OR OVERNIGHT!

(Sign in the presence of a notary)

Parent/Guardian Signature

NOTARY STATEMENT: STATE OF FLORIDA, COUNTY OF MARION

On before me personally appeared, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the instrument and acknowledged to me that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument, the person or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal: