

OVERNIGHT
 OUT-OF-STATE
 OFF CAMPUS

LAKE COUNTY SCHOOLS
FIELD TRIP/SCHOOL ACTIVITY
PARENT CONSENT/LIABILITY WAIVER/MEDICAL RELEASE

Student _____ School South Lake High School
Club/Group/Class SLHS Band Program Supervising Faculty Member Mr. Ryan F. Wright
Activity All SLHS Band Program Events Location Various
Date & Time of Departure Various (www.slhsband.com) Date & Time of Return Various (www.slhsband.com)
Method of Transportation : School Bus Charter Bus Private Car Leased Vehicle Walking Other

MEDICAL INFORMATION

Does your child have any of the following conditions?
Epilepsy/Seizures Yes No Motion Sickness Yes No Diabetes Yes No
Any Medication Yes No Asthma/Wheezing Yes No Heart Disease Yes No
Muscular/Skeletal Problems Yes No Hemophilia/Bleeding Disorders Yes No

Is there any other condition which might possibly require treatment and/or medication during the trip? Yes No If yes, you must complete and attach the Administration of Non-Prescription Medication Consent Form and/or the Administration of Prescription Medication Consent Form.

PARENT CONSENT / LIABILITY WAIVER / MEDICAL RELEASE

I/We hereby give permission for my child to accompany employees of the LCSB, acting as chaperones, to All SLHS Band Events for the days indicated above. I/We will not hold the LCSB nor their agents or employees accompanying the group responsible for any accident or injury to my child/ward.

In the event my child/ward 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 LCSB, its agents and employees.

I/We have read all the information in regards to this trip. I/we are aware of guidelines of said trip and the number of chaperones which will accompany my/our child/ward.

I/We hereby grant permission to the attending physician or his consulting physicians, to render to my/our child/ward any emergency treatment, medical or surgical care that might be deemed necessary to the health and well-being of said child/ward. Also, when necessary for the administering of such care, I/we 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/ward or my/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/ward's physical condition change in any way and any time so as to affect his/her participation in the activity herein named.

I/We further relieve and release said LCSB from any liability in its failure to carry insurance upon my/our said child/ward.

Our/My child/ward has medical insurance Yes No If yes, you must complete and attach a copy of proof of insurance to this form.

Insurance Co _____ Policy # _____

Home Phone _____ Work Phone _____ Cell Phone _____ Emergency Phone _____

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

THIS SECTION MUST BE COMPLETED BY PARENT/GUARDIAN ONLY IF CHILD/WARD IS GOING OUT-OF-STATE OR OVERNIGHT!

Parent/Guardian Signature (SIGN IN PRESENCE OF A NOTARY)

NOTARY STATEMENT STATE OF FLORIDA, COUNTY OF LAKE

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 _____

One copy must be retained by the administration and a duplicate copy must accompany the sponsor when leaving school property with students.