

**CHARLOTTE COUNTY PUBLIC SCHOOLS, FLORIDA
OFF-CAMPUS SECONDARY SCHOOL ACTIVITY
PARENTAL/GUARDIAN CONSENT FORM**

SCHOOL _____

SCHOOL # _____

STUDENT INFORMATION, ACTIVITY/LOCATION AND METHOD OF TRANSPORTATION (To be completed by school)

I/We hereby grant permission for _____

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Name of Student

Student I.D. #

to participate in an off-campus school activity:

_____ on _____
Activity(s) and location(s) Date

and to make incidental stops enroute and return when determined to be necessary or desirable. I/We understand the method of transportation will be: School Bus _____ Private Vehicle _____

I/We understand that under present law, if my/our child is riding in a private passenger automobile which is involved in an accident, he/she will be primarily covered for bodily injury under my/our family automobile policy, and I/we agree to submit any medical bills incurred to my insurance company for payment. If my/our policy has been issued with a deductible clause relative to the personal injury protection, I/we understand that I/we have assumed the deductible amount when I/we purchased the policy.

I/We on behalf of ourselves, our heirs, executors, successors, and assigns, consent to medical treatment and 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 is physically fit and able to participate in the activity and I/we have not been advised or informed by anyone to the contrary. (SEE NOTE BELOW)

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.

Signature of Student/Date Signature of Parent/Guardian/Date

Home Address Home Telephone Number Emergency Telephone Number

Teachers, if approved, please initial in the appropriate space. If not approved, write no. It is understood that the student is responsible for all work assignments in his/her classes.

PERIOD	1	2	3	4	5	6	7
COURSE	_____	_____	_____	_____	_____	_____	_____
TEACHER	_____	_____	_____	_____	_____	_____	_____

NOTE: IF THERE IS ANY PHYSICAL CONDITION TO THE CONTRARY, DESCRIBE IN THE MEDICAL INFORMATION SPACE PROVIDED BELOW:

MEDICAL INFORMATION

This is very important! It is included to assist the Activity Director/Teacher in assuring your child's well being. Please list any known allergic reactions (bees, ants, medications, etc.) Indicate any condition such as asthma, wheezing, heart disease, seizures, diabetes, muscular or skeletal problems, or any other medical condition you would like called to the schools' attention. Feel free to call the school in advance of the activity date to discuss any specific health problems.

White: Teacher/Sponsor
MIS# 9021-003889

Yellow: School Office

Pink: Parent