

SCHOOL DISTRICT OF OKALOOSA COUNTY
ON/OFF-CAMPUS SCHOOL ACTIVITY

TO: Parent/Guardian

FROM: School Principal (This Form Must Be Notarized)

Your son/daughter is eligible to participate in a school-sponsored activity requiring transportation to a location away from the school building. This activity will take place under the guidance and supervision of employees from Fort Walton Beach High School. A brief description of the activity follows:

Name of Event: FWBHS Band Activities Destination: All Band Events
Designated Supervisor of Activity: Randy Folsom/Daniel Farr
Date: Current school year Method of Transportation: School and/or Commercial Buses

If you would like your child to participate in this event, please complete, sign and return the following statement of consent by _____. As parent or legal guardian you remain fully responsible for any legal responsibility which may result from any person actions taken by the named student.

If your child requires prescription medication to be administered during this activity, you must speak with the designated employee prior to the activity. Parent's must supply any listed medications in their original prescription container and provide a completed MIS 5183 Administration of Medication in the School Permission Form.

I hereby consent to participation by my child _____ in the event(s) described above. I understand that this event will take place away from the school grounds and that my child will be under the supervision of the designated school employee on the stated dates. I further consent to the conditions stated above on the participation in this event, including the method of transportation and required information on medications.

PRINT or TYPE Parent/Guardian Name Date Signature of Parent or Guardian

PARENT/GUARDIAN PERMISSION FOR EMERGENCY TREATMENT

On rare occasions an emergency requiring hospitalization, surgery, and/or other medical treatment develops. The designated supervisor of this activity will attempt to contact the parent/guardian prior to emergency treatment consent. In some countries/states, students under 21 years might not be administered an anesthetic or operated upon without the written consent of the parent/guardian; therefore we request the parent/guardian to sign the following statement. This is to prevent a dangerous delay in case an emergency does occur and we are unable to contact the parents.

In the event of injury and/or illness to our son/daughter _____ Born _____
Student Name Month/Day/Year

Address _____
Street City State Zip Code

Health Insurance Plan and Plan Number _____

We hereby authorize an Okaloosa County School District principal and/or designee who is employed on the students District school campus to obtain and give consent to whatsoever medical treatment the representative deems necessary, including the administration of an anesthetic and surgery, and do hereby release the Okaloosa County School District and the representative from any and all claims which may arise from the representative's obtaining and consenting to said medical treatment.

Please PRINT or TYPE Name Date Signature of Parent or Guardian

Telephone Number Emergency Contact Person Emergency Telephone Number

Comments: _____

STATE OF FLORIDA * COUNTY OF OKALOOSA

The foregoing instrument was acknowledged before me this _____ Date By: _____ Name of Person Acknowledged

Who is personally known to me or who has produced _____ Type of Identification

As identification and who did / did not take an oath.

Signature of Person / Notary taking Acknowledgement Name of Acknowledger Typed, Printed or Stamped

**FORT WALTON BEACH HIGH SCHOOL BAND
MEDICAL RELEASE/INFORMATION FORM School Year 20____ - 20____**

Parent or Guardian's authorization for students traveling with the Fort Walton Beach High School Band. This authorization is good for a period of one (1) year from date of signing.

Student Name _____ Sex _____ Age _____ Grade _____
 Birthday _____ Home Phone _____ Cell Phone _____
 Address _____
 Mother's Name _____ Business Phone _____ Cell Phone _____
 Father's Name _____ Business Phone _____ Cell Phone _____
 Health Insurance Company _____ Policy # _____
 Family Physician _____ Phone _____

Please list an emergency contact person in the event that you are unavailable.

Name _____ Relationship to Child _____
 Home Phone _____ Work Phone _____ Cell Phone _____

Date of Last Tetanus Shot _____

**May the Band Director or Nurse in charge give your child the following?
 If left blank, medications cannot be given without parental consent.**

	YES	NO		YES	NO
Tylenol (for headache or pain)			Dramamine (for motion sickness)		
Motrin (for headache or pain)			Sinus Medication and/or Antihistamines		
Benadryl (for insect bites, allergic)			Antacids (Tums, Pepto-Bismol)		
Cough Drops			Minor First Aid		

Please list if your child has had any of the following:

ALLERGIES to Medications _____
 Environmental (bees, etc) _____
 Food (peanuts, etc) _____

ASTHMA _____ **INHALER NAME** _____

DIABETES _____ **TYPE** _____ **Rx** _____

EPILEPSY _____ **TYPE** _____ **Rx** _____

HEART CONDITIONS _____ **Rx** _____

FREQUENT HEADACHES _____ **Rx** _____

FREQUENT NOSEBLEEDS _____ **Rx** _____

KIDNEY PROBLEMS _____ **Rx** _____

HEMOPHILIA _____ **RHEUMATIC DISEASES** _____ **Rx** _____

WEARS CONTACT LENSES _____ **GLASSES** _____

IS YOUR CHILD ON ANY OTHER MEDICATIONS? _____ **If YES, please list** _____

IS PARENT SENDING ANY MEDICATION WITH STUDENT WHEN TRAVELING? _____

(Requires Additional County Form MIS 5183, "Administration of Medication in the School Permission Form")

Medication supplied by the parent **must** be in the original prescription container clearly labeled with the students name, the medication name, dosage, and time to be given. If any medications are listed, parent or guardian **must** speak with the designated employee **prior** to the activity.

If during the school year, the student has any contagious disease, serious illness or accident, or if any of the above information changes, please notify the nurse traveling with the band.

PARENT'S AUTHORIZATION:

I certify that the above history is correct as far as I know. I further certify that in the event I cannot be reached in an emergency, I hereby give permission to the Physician selected by the Nurse or Band Director to perform such treatment as he may deem necessary to preserve the health of my child.

 TYPED or PRINTED NAME

 SIGNATURE

 DATE