Form No. TRNS 0082 **Appendix A**

THE SCHOOL BOARD OF POLK COUNTY, FLORIDA
BLANKET FIELD TRIP PERMISSION FORM

TO WHOM IT MAY CONCERN:

_____ has my permission to participate in all field trips to be taken by
(Name of Student)

KATHLEEN HIGH SCHOOL BAND, during the _____ school year.
(Name of Organization/Group (Year)

As parent/guardian I acknowledge the following:

1. School officials are authorized to obtain emergency medical treatment for this student as necessary.

2. The School Board has made available to this student the opportunity to purchase student accident insurance.

3. During this field trip, that the School Board will not be liable for injury to this student as result of the negligence, errors, and omissions of others (i.e., charter bus owners and drivers, or amusement park owners or workers), their agents, heirs, employees or assigns either through their action or inaction.

4. If your child takes personal belongings on this field trip, he or she will be responsible for them. The School Board accepts no responsibility for personal items, such as watches, purses, money, cameras, and wallets, etc. If a student stores personal items in a locker at an amusement park, that entity may be responsible for any loss or damage.

_____ _____
(Signature of Parent/Guardian) (Date)

NOTES:

1. THIS BLANKET FORM MAY BE USED FOR TRIPS OF A SIMILAR NATURE, WHICH ARE REPEATED DURING THE SCHOOL YEAR.
2. FOR ALL OUT-OF-COUNTY TRIPS, A NOTARIZED MEDICAL TREATMENT AUTHORIZATION FORM MUST ALSO BE AVAILABLE. THE MEDICAL FORM MUST BE COMPLETED PRIOR TO THE STUDENT'S FIRST OUT-OF-COUNTY TRIP AND SHOULD BE RETAINED FOR USE DURING THE REMAINDER OF THE SCHOOL YEAR.

Form No. TRNS 00797 **Appendix C**

THE SCHOOL BOARD OF POLK COUNTY, FLORIDA
MEDICAL TREATMENT AUTHORIZATION FORM

TO WHOM IT MAY CONCERN:

I the undersigned parent/guardian of _____ hereby authorize any
(Name of Student)
necessary medical treatment for this student while participating in field trips conducted under the

sponsorship of KATHLEEN HIGH SCHOOL, during the _____ school year,
(Name of School) (Year)
and guarantee payment of all charges incurred as a result of this medical treatment.

INFORMATION:
ALLERGIES TO FOOD, MEDICATION, ETC. (If none, so state.) - _____
_____
SPECIAL MEDICAL CONDITIONS (If none, so state.) - _____
_____
FAMILY PHYSICIAN - _____
OFFICE ADDRESS - _____ PHONE NO _____
PARENT/GUARDIAN NAME – (Please print) _____
PARENT/GUARDIAN HOME ADDRESS - _____
HOME PHONE _____ (Street Address)
WORK PHONE _____ _____
(City) (State) (Zip)

_____ _____
(Insurance Company) (Policy No. or Group No.)

PARENT/GUARDIAN SIGNATURE _____ DATE _____

STATE OF FLORIDA, COUNTY OF _____
I hereby certify that the foregoing was executed before me this _____ day of _____,
by _____, who is personally known to me or who has produced
_____ as identification and who did (did not) take an oath.

_____ _____
Notary Public, State of Florida Notary Seal

THIS FORM IS TO BE USED FOR ALL OUT-OF-COUNTY FIELD TRIPS EXCEPT ATHLETIC ACTIVITIES. THE FORM SHOULD BE COMPLETED PRIOR TO THE STUDENT'S FIRST OUT-OF-COUNTY TRIP AND RETAINED ON FILE FOR THE REMAINDER OF THE SCHOOL YEAR. **THIS FORM IS TO BE TAKEN ON ALL FIELD TRIPS.**