★ JAZZ ENSEMBLE ★

ST. JOHNS COUNTY SCHOOL DISTRICT
PARENT PERMISSION FORM FOR FIELD STUDY ACTIVITIES

School: Freedom Crossing Academy

I/We, the parents/guardians of the student named below, understand the nature of the activity being planned to: Holiday

Lakeside Jazz Festival, Port Orange FL on 4-19-2024 Friday
(DATE)

Time: Leave: 8:00 am Return: 7:00 pm This field study includes a supervised water activity: Yes ____ No X

School Bus at a cost of $ X
(MODE OF TRANSPORTATION) $ Students bring money for concessions

We acknowledge our student is in good health and the study does not pose a health hazard to my student. ***We also understand in times of national emergency or any other time when it is in the best interest of the health, safety and welfare of students and employees, the School Board may revoke its approval assuming no liability for reimbursement of costs or expenses incurred by the cancellation of any activity.***

I/We hereby grant permission and give my/our consent for my student to (1) be treated by any qualified nurse, physician, or surgeon as may be deemed necessary by the district, its agents, servants, or employees during the activity; (2) be administered medication and/or emergency first aid care as may be necessary or appropriate; and (3) receive treatment in hospitals, medical offices, or elsewhere in the event of accident or illness. To assist in that medical care or treatment, I/we represent that the medical information supplied on the Medical Information Form and or the School Health Card is true and accurate The district, its agents, servants, or employees are not responsible for acts or omissions of third parties as a result of securing medical care. I/We will hold the district and its agents, servants, or employees harmless and indemnify them from any claim, cause of action or demand arising out of any form of or the lack of medical or emergency treatment rendered to my student.

In the event that a student must return to school independently for reasons of health, accident, failure to conform to rules established by the teacher in charge, etc., we agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses. This permission slip also serves as a contract that the student and parent(s) understand and agree to the guidelines from each teacher as to making up missed assignments.

My student, by his/her signature hereto, fully agrees and consents to the foregoing with permission to participate in the listed field study.

Student's Name (Print): _____

_____ _____
Signature of Student Date

My student requires medication and/or medical attention: YES ____ NO ____

If yes, you must complete the Medical Information Form (obtained from the activity supervisor) and provide the medication to the personnel trained to administer the medication.

_____ _____
Signature of Parent/Guardian Date

_____ _____ _____
Cell Phone Work Phone Home Phone

Emergency contact, if parent unavailable _____ Phone _____

Family Physician _____ Phone _____

Health Insurance Provider _____ Policy# _____

Board Approved 8.12.14 (Revised October 2017)

Due on Tuesday, April 16

★ Band Polo + long blue jeans ★

MEDICAL INFORMATION FORM

(Required for any student requiring medication or medical attention)

Child's Name: _____

Date of Birth: _____

Health Insurance Provider and # of Medical Plan: _____

_____

Doctor's Name & Phone #: _____

Parent's Contact Number: Cell: _____ **Work:** _____ **Other:** _____

If parents cannot be reached in an emergency, please contact:

Name: _____ **Phone #:** _____

LIST ANY AILMENTS, DISABILITIES OR PROBLEMS INVOLVING YOUR CHILD WHICH MIGHT AFFECT HIS/HER PARTICIPATION.

Asthma_____
Allergies_____
Bronchitis_____
Bed Wetting_____

Diabetes _____
Ear Infection_____
Epilepsy_____
Heart Disease_____

Nightmares_____
Sinus_____
Sleepwalking _____
Other _____

Information of which sponsors should be aware:

1. Unusual reactions or allergies to drugs.
2. Special care needed while on activity.
3. Special instructions to medical personnel if emergency care is needed.
4. Significant health problems of student.

All prescription and non-prescription medication to be administered by trained school personnel during the field study must have an Authorization to Administer Medication form signed by both the parent/guardian and the physician ordering the medication if not already on file in the school clinic. All medication must be received in the original container with current Rx label including student's name, dosage, and frequency of administration, physician's name, and expiration date of medication. All non-prescription medication in the possession of students at the middle and high school level not administered by school personnel must be in the original container and requires written permission from the parent to the school.

All medication and required documentation must be cleared through the **School Clinic** prior to the field study.

Name of Medicine: _____

What it is to be used for: _____

How it is to be given: _____ Quantity to be given: _____ Time to be given: _____

Parent's Signature _____

IN CASE OF EMERGENCY: I hereby request the physician/emergency team selected by the supervisor provide treatment for my child named above.

Name: (Print) _____

Parent's Signature: _____ **Date:** _____