SARASOTA MILITARY ACADEMY
3101 Bethel Ln. Sarasota, FL 34240

MEDICAL RELEASE FORM FOR OUT OF COUNTY OR OVERNIGHT TRAVEL

Instructions: **Form must be signed and notarized.**

Name Of Student (*Please Print*): _____ **School Year:** 2021-2022

Address: _____ **Date Of Birth:** _____

Home Phone: _____ **Parent's Work Phone:** _____ **Cell Phone:** _____

Other Emergency Contact Name: _____ **Phone :** _____

Medical Insurance Carrier: _____ **Policy Group Number:** _____

This application to travel and participate in activities or events sponsored by the Sarasota Military Academy is entirely voluntary on our part and is made with the understanding that we have not violated any of the eligibility rules and regulations of the Florida High School Activities Association or the Sarasota County Schools. It is also agreed that we will abide by all the rules set down by the School Board of Sarasota County, the Florida High School Activities Association, and the school.

The Sarasota Military Academy, its school principals and teachers, desire that students and parents or guardians of students have a thorough understanding of the implications involved in a student participating in a voluntary extracurricular activity. For this reason it is required that each student in the Sarasota County Schools, his/her parent, parents, or guardian, read, understand, and sign this agreement prior to the student being allowed to participate in any out-of-county or overnight school trip.

1. I/We the undersigned, as parent, parents, or guardian, give my/our consent for the student identified herein to participate in this activity as a representative of his/her school.
2. I/We will not hold the Sarasota Military Academy, anyone acting in its behalf, or the Florida High School Activities Association responsible or liable for any injury occurring to the named student in the course of such activities or such travel. I/We release the Sarasota Military Academy, its employees, and agents from all claims, costs, trips or extracurricular activities, including any claims, costs or damages arising from the negligence of the School Board of Sarasota County, its agents, or employees.
3. I/We understand that school officials will complete accident insurance forms, if the student has school insurance, after which all claims under insurance policy, or policies, for injuries received while participating in school events, shall be processed by the student, his/her parent, parents, or guardian through the company agent handling the student's insurance policy, and <u>not</u> through the school officials.
4. I/We hereby accept financial responsibility for equipment or instruments lost by the student identified herein.
5. I/We authorize the school to transport and to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such activities or such travel.
6. I/We also agree that the expenses for such transportation and treatment shall not be borne by the school district or its employees.
7. I/We accept full responsibility and hereby grant permission for my son/daughter to travel on any approved school related trip. This statement remains in effect until the end of this school year unless cancelled by me in writing to the school.

Student Signature: _____ Date:_____

Parent/Guardian Signature:_____ Date: _____

State of _____ County of _____

The foregoing instrument was acknowledged before me by means of____ physical presence or ____ on line notarization, this _____day of _____, 20 _____,

By _____ (name of person acknowledging)

____ Personally known to me, or

____ Produced Identification: _____ Type of Identification Produced: _____

Notary Public Signature: _____

Name of Notary Public: Print, Stamp, or Type as Commissioned: _____

My Commission Expires: _____ Commission Number: _____

The School Board of Sarasota County and Sarasota Military Academy comply with State statutes on veterans' preference and Federal statutes on nondiscrimination on basis of religion, race, national origin, color, sex, or handicap.

SARASOTA MILITARY ACADEMY

EMERGENCY MEDICAL TREATMENT FIELD TRIP CONSENT FORM

Name of Student: _____ Date of Birth: _____
Last First Middle

Home Address: _____
Street City Zip Code

Parent/Guardian: _____ Relationship: _____

Address of above (if different): _____
Street City Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please list a person other than the parent or guardian who could be contacted in case of an emergency:

Emergency Contact:_____ Phone #: _____

Is the student allergic to foods, medications, or insects? _____ Yes _____ No

If Yes, please list what they are and emergency medication/treatment, if any:

_____

_____

Does the above student have any chronic medical problems (such as asthma, diabetes, seizures)? ____ Yes ____ No

If Yes, please list and describe medical requirements for field trip: _____

_____

Does the above student take any daily medication? _____ Yes _____ No

If Yes, please complete the medication treatment authorization form (if not previously on file in the school Health Clinic) and list the medication and time to be administered:

_____

_____

Family Physician: _____ Physician Phone: _____

In case of serious illness or injury where immediate care is needed, the school or its representative has my permission to contact the appropriate emergency medical service. The emergency medical service has my consent to provide necessary treatment or transportation for my child. I then request that I be notified of the situation. The undersigned will be responsible for emergency treatment cost.

In the case of an accident or illness where immediate treatment of my child is not indicated, but where (s)he is unable to remain at the field trip, I request that the school contact me or my designee to arrange transportation for my child. If the school is unable to contact me, I request that the other person listed on this form be contacted and requested to care for my child. I understand that I must notify the school if there are any changes in this health emergency information.

List hospital preference for non-life threatening emergency : _____

Parent/Guardian Signature: _____ Date: _____