WILLIS INDEPENDENT SCHOOL DISTRICT
WILLIS HIGH SCHOOL
AIR FORCE JUNIOR RESERVE OFFICER TRAINING CORPS
PARENT PERMISSION for AFJROTC TRAVEL and/or to OBTAIN EMERGENCY MEDICAL CARE
SCHOOL YEAR 2024-2025

Parents or guardians must complete the following information and return to Air Force Junior ROTC at Willis High School before their son/daughter will be allowed to participate in AFJROTC activities.

I authorize my son/daughter, _____ to travel and participate in
Printed Cadet Name
any or all scheduled Air Force Junior ROTC activities necessary to fulfill Curriculum In Action, Leadership Development Activities and Community Service requirements of the Air Force Junior ROTC program. All travel will be via Willis Independent School District (WISD) approved transportation. I take full responsibility for the conduct and behavior of my son/daughter while participating in any Air Force Junior ROTC activities sponsored by the WISD. In granting this authorization, I understand that all reasonable safety precautions will be taken by authorized personnel of the WISD to ensure the safety and well-being of my son or daughter while participating in sponsored travel and associated field activities. Therefore, I release the Willis Independent School District, the United States Government, their agencies, their employees and volunteers from all liability resulting from accident and associated injuries involving my son/daughter while traveling to or from or otherwise participating in associated field activities.

In the event of a medical emergency, while participating in an approved WISD activity, I authorize the AFJROTC Aerospace Science Instructor in charge (or in his absence the responsible chaperone), or WISD employee, to provide qualified medical attention for my son/daughter as necessary. My son's/daughter's emergency medical data follows:

a. Name of Health Insurance Company: _____
   Policy Number: _____, Expiration date: _____
   Parent's Home Phone: (____) _____, Work Phone: (____) _____

b. Name of 24-Hour Emergency Contact: _____
   Relationship: _____, 24-Hour Phone: (_____) _____

c. Name of Family Physician: _____, Office Phone: (_____) _____

I certify all the information given above is true and accurate to the best of my knowledge.

_____ _____
Printed Name of Parent or Legal Guardian Signature

_____
Date

THIS AUTHORIZATION WILL REMAIN IN EFFECT FROM August 2024 to July 2025
UNLESS SOONER RESCINDED BY EITHER PARENT OR LEGAL GUARDIAN IN WRITING