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

TO WHOM IT MAY CONCERN:

_____ has my permission to participate in all
Name of student
field trips to be taken by _____
Name of organization/group

during the _____ school 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 AppendixD

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 necessary

medical treatment for this student while participating in field trips conducted under the sponsorship of

_____ during the _____school year and
Name of School

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 PHYSICLAN _____ _____
OFFICE ADDRESS _____PHONE NO _____
PARENT/GUARDIAN NAME. _____ _____
Please Print
PARENT/GUARDIAN HOME ADDRESS, _____
HOMEPHONE _____ Street Address
WORKPHONE. _____ _____
City

Insurance Company Policy No. or Group No.

PARENT/GUARDLAN 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

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

English Version 8100