

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

School: Ketterlinus Elementary School - FUN RUN 2/5/25 & FIELD DAY 3/13/25

I/We, the parents/guardians of the student named below, understand the nature of the activity being planned to:
on 2/5/2025 & 3/13/2025
(DATE)

Time: Leave: 8:30 AM Return: 1:30 PM This field study includes a supervised water activity: Yes No

Walking to Francis Field at a cost of \$ 0

(MODE OF TRANSPORTATION)

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#

Medical Information Form

(Required for any student requiring medication or medical attention)

Student's Name: _____ Date of Birth: _____

Health Insurance Provider and Medical Plan # _____

Parent/Guardian's Name: _____ Contact Number(s): _____

Doctor's Name & Phone Number: _____

Emergency Contact Name & Phone Number: _____

List any ailments, disabilities or problems involving your child which may affect her/his participation.

Allergies (Food) _____ Allergies (Seasonal) _____
Asthma _____ Diabetes _____
Epilepsy _____ Other _____

Information sponsors should be aware of:

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

An employee trained to administer medication must accompany students needing prescribed medication during field study hours. All medications (prescription and over-the-counter) must have an Authorization to Assist in the Administration of Medication/Treatment form signed by both the parent/guardian and the physician ordering the medication, if not already on file in the school clinic. All medications must be received in the original container with the current Rx label including student's name, dosage, frequency of administration, physician's name and expiration date of the medication (the expiration date on the pharmacy label, not on the medication box, will be the expiration date). Over-the-counter medications must be in the original, unopened container. EXCEPTION: Students at the middle and high school level may carry a non-prescription, non-emergency medication on his/her person while in school with written permission from the parent/guardian. A copy of the signed permission form must accompany the stated medication at all times.

Name and purpose of medication: _____

How it will be given: _____ Time to be given: _____

Parent/guardian's signature: _____

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

Parent/guardian's signature: _____

Date: _____