THE SCHOOL BOARD of ST. LUCIE COUNTY, FL
Parental Permission, Release, Indemnity, Medical and Insurance Statement

Your child has enrolled in the **Academy of Medical Science**.

Part of this training will take place in a business or medical establishment within the community, so your child will need to be transported by school transportation and or in a private vehicle.

I/We, the undersigned parent/guardian grant_____ permission to travel to his/her
(Student Name)
place of learning during the school year 20 __- __. If my child travels in a private vehicle the School Board will not incur any expense. I/We hereby waive any and all claims, against the School Board and its employees, for any damage, injury, loss, liability or expense sustained during this activity.

I/We agree to indemnify, and hold the School District and its employees harmless against any and all claims, actions, and demands for any damage, injury, liability or expense incurred as a result of the student riding or driving private transportation to attend any activity for the Academy of Medical Science.

Parent/Guardian Signature:_____

Print Name: _____ Relationship: _____

Student Medical History

Name_____ Sex (Check One): Male___Female___ Social Security #_____
Home Address _____
Home Phone _____Additional Numbers _____

Has your child ever had (please check all that apply)

☐ Asthma	☐ Fainting	☐ Weak Back	☐ Allergy_____
☐ Frequent Headaches	☐ Diabetes	☐ Epilepsy	☐ Other _____

In the event of an accident, personal injury or illness, my signature grants permission for my son/daughter to be treated at the nearest medical center or doctor's office. I also agree to release medical information as required by the clinical site. In the event of an accident, personal injury or illness, the Medical Academy instructor, clinical agency staff member or school has my permission to transport my son/daughter to the appropriate facility.

Parent/Guardian Signature:_____

Health Insurance

My child is covered by a 24-hour health/accident insurance with:
Insurance Company _____ Policy Number _____
Address_____

☐ I do not have health insurance and I accept any and all liability.

In case of an emergency I can be reached at:
Parent Name_____
Home Address_____
Place of Employment _____ Employment Phone _____ext._____

NOTARIZATION

State of Florida/County of St. Lucie
Sworn to and subscribed before me this _____ day of _____, 20_____.

_____ My Commission Expires: _____
Notary Public

White: Canary: Data Specialist CUR0023 Rev. 4/08