FIELD TRIP, MEDIA, & MEDICAL RELEASE FORM
Homeschool Athletes

I give my permission for _____; Grade_____ to participate in all sports and school sponsored trips away from the school premises throughout the current school year. Students will be accompanied by a teacher and will be under adequate supervision.

Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I/we understand that there are risks/dangers involved with participation in off-campus trips and their associated activities. In consideration of my child being allowed to participate in this event, I/we assume responsibility for those ordinary and reasonable risks associated with the travel and activities. I/we agree to hold harmless East Hill Christian School, its affiliated organizations, employees, agents and representatives, including volunteer and other drivers, from any and all claims arising from my child's participation.

In case of accident, illness or other emergency, I/we request that the school contact me/us. If the school cannot reach a parent/guardian after conscientious effort, I/we give permission for school staff to call licensed paramedics, physician or dentist. If a life-threatening emergency exists I/we give permission for school staff to call paramedics immediately and to contact me/us as soon as possible thereafter.

I/we authorize and consent to any X-ray, examination, anesthetic, medical, dental or surgical diagnosis or treatment, and hospital care which is in the best judgment of a licensed physician or dentist, is deemed advisable. I/we also agree to be financially responsible for emergency medical transportation.

PARENT CONTACT INFORMATION:

Father's Name *Printed*_____ Mother's Name *Printed*_____
(If the child lives with both parents, the release must be signed by both parents/guardians)

_____ _____
Father/Guardian's *Signature* Date Mother/Guardian's *Signature* Date

Father's Work #_____ Cell #_____ Email_____

Mother's Work #_____ Cell #_____ Email_____

EMERGENCY CONTACT INFORMATION: In case of emergency, please list persons we should contact if we are unable to contact the numbers above.

Name:_____ Relationship _____ Phone #_____

Name:_____ Relationship _____ Phone #_____

Physician:_____ Phone # _____

Dentist:_____ Phone #_____

Preferred Hospital:_____ Blood Type: _____

Health Insurance Carrier:_____ Policy #_____

Under the Name of:_____ Relationship to Student:_____

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____ DAY OF _____, _____.

_____
Notary Public, State of Florida

PLEASE BE SURE TO FILL OUT BOTH SIDES OF THIS DOCUMENT

STUDENT HEALTH HISTORY

NAME: _____ DOB: _____ AGE: _____ SEX: _____

Parent's or guardian's Permission: I certify that this information is true and I consider him/her physically capable of participating in school activities and/or athletics. I understand that this history is not a complete one, but a screening exam for participation in an athletic program. I will bring to the attention of the school staff during the year, any medical problems that might affect his/her health. I authorize the school to obtain, through a physician of its own choice any emergency medical care that may become necessary for the student in the course of such activities. I also agree not to hold the school or anyone acting in its behalf, responsible for any injury or emergency treatment of such injuries occurring to the above named student.

List Allergies (including reactions to medications): _____
List Medication being taken on a regular basis: _____

YES	NO	
		Any Asthma, if yes do they use an inhaler:
		Any diabetes, if yes talk to coach and explain emergency procedure
		Any other chronic illness, if yes explain:
		Any illnesses lasting more than one week
		Any bleeding tendencies
		Any yellow jaundice
		Any hospitalizations
		Any surgery other than tonsillectomy
		Any injuries requiring treatment by a physician
		Presently taking any medications, if yes explain:
		Any dizziness, fainting, convulsions, or frequent headaches
		Ever been knocked out
		Wear glasses or contact lenses
		Wear any dental appliances
		Allergic to any medications, if yes explain:
		Any knee, ankle, neck or joint injuries:
		Any sprains or dislocations
		Any broken bones
		Any organ missing (Appendix, Eye, Kidney, etc.), if yes explain:
		Any heat exhaustion or stroke
		History of family member under 50 (heart attack or heart problems)
		Have there been any health problems in the last year
		Any loss of consciousness or severe headaches
		Do you know any reason why this applicant should NOT participate in sports

Are there any physical or medical conditions we should know about not already stated?_____
_____

May we administer the following medications to your child? Permission to Treat _____YES _____ NO
Acetaminophen (Tylenol) ___ Ibuprofen (Advil) ___ Cough Drops ___ Antacid (Tums) ____

*Any prescription medications taken at school need to have appropriate forms (filled out by the doctor) along with the original bottle with students name on it taken to the student office.
**Any non-prescription medications you would like available for your child to be brought to the student office in a Ziploc bag labeled with the students name and appropriate paper work filled out. (Forms available in the Front Office)

MEDIA RELEASE

By initialing, you give permission for your child(ren) to be included in advertisements, photos, film footage of EHCS, and promotional materials. It is understood that you are giving permission for your child(ren) to be included until you state otherwise. _____ His/her name MAY / MAY NOT be included with his/her picture. (**please circle one**).

PARENT SIGNATURE_____DATE_____