CUBA INDEPENDENT SCHOOL DISTRICT

THE CUBA INDEPENDENT PARENT / GUARDIAN

SCHOOL PERMISSION SLIP / MEDICAL AUTHORIZATION / INDEMNITY AGREEMENT

Created 10-5-2013

SPONSOR OF ACTIVITY_____

ACTIVITY_____

DATE(S) OF ACTIVITY_____

PLACE OF ACTIVITY_____

CURRICULUM JUSTIFICATION:_____

_____

TRANSPORTATION TO BE USED: _____

The undersigned as parent or legal guardian of _____, does hereby give permission for the above named individual to attend the described activity.

As a condition of attending the described activity, I do hereby release The Cuba Independent School District and all its organizations, as well as their officers, agents and employees, from any and all claims, demands, actions, or causes of action due to death, injury, or illness, in any way, arising from the above described activity, including, but not limited to transportation to and from the event.

I further agree that the financial responsibility for securing care, in case of injury resulting from participation in the program, is a matter between the participant and his/her health care provider, and that The Cuba Independent Schools cannot pay health care providers for treatment of any injuries. It is further agreed, that the participant will assume all legal responsibility for their personal safety and actions while participating in the program and while traveling to and from the program activities.

I hereby authorize the Supervisor of the activity or his/her designee to act in my behalf to authorize such medical attention, surgery, or other health care services, as may be recommended in an emergency situation while participating in the activity. If the below named physician cannot be reached, I hereby authorize any licensed physician or medical center to treat my child.

I hereby authorize the Supervisor of the activity or his/her designee to administer the following medication to my child according to the instructions described here:

Medication _____

Directions: _____

If the medication is prescribed by a doctor, the prescription in its original container will be provided to the Supervisor of the activity.

Name of Physician_____Phone_____

Signature:_____Date:_____
Parent/Guardian

Phone:_____ _____
Home / Cell Work

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