



**PLEASE PRINT AND STAPLE TOGETHER.**

**RETURN ALL OF THESE  
FORMS AT THE SAME TIME.**

Cypress Bay High School  
18600 Vista Park Blvd  
Weston, FL 33332  
phone/fax:(754) 323-0398  
[www.cypressbayband.com](http://www.cypressbayband.com)



**Cypress Bay Band Parent Association**  
Supporters of the Cypress Bay High School "Sound of Thunder" Band

www.cypressbayband.com

18600 Vista Park Blvd  
Weston, FL 33332

phone/fax: (754) 323-0398

**PERMISSION AND MEDICAL RELEASE FORM**

\_\_\_\_\_  
Last Name/First Name

\_\_\_\_\_  
Student Number

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone

I/WE, the undersigned, hereby grant permission for my/our son/daughter, as a member of the Cypress Bay Band, to participate in any Band related activities, and to accompany the Band or Units thereof on any field trips, local or otherwise. By my/our signature, we hereby release and hold harmless Cypress Bay High School and the individual principal, teachers, parents, and other chaperones, from all liability for mishaps or injuries to the above named student, from starting time of the event until the finish, and from any and all responsibility for the acts of conduct of such student during the activity. I/WE also give permission for a school official or appropriate Band Parent member to request emergency medical treatment, should my/our child become ill or injured while participating in any Band related activity. I/We also agree to pick up my/our child from any event, or reimburse any costs of transportation to send the student home if the director deems the student's behavior to be so egregious as to jeopardize other students' enjoyment of, or safety on the trip. I/We understand it is our responsibility to pick up our student from the designated site at the given approximate ending time. I/We understand that all monies paid for any trip are non-refundable. I/WE further signify that the student listed above is fully insured by the following company:

**INSURANCE INFORMATION**

\_\_\_\_\_  
Name of Company

\_\_\_\_\_  
Type of Policy

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Policy Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone

**MEDICAL INFORMATION**

Any medical conditions we should be aware of: \_\_\_\_\_

Please List Allergies: \_\_\_\_\_

**EMERGENCY INFORMATION**

Primary:

\_\_\_\_\_  
Contact

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Relationship

Secondary:

\_\_\_\_\_  
Contact

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Relationship

Family Physician:

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**AUTHORIZATION FOR MEDICATION / TREATMENT**

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

\*\*\*\*\*

**Allergies:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	SPECIAL INSTRUCTIONS/SIDE EFFECTS

**TREATMENTS DURING SCHOOL HOURS**

Treatment Plan: \_\_\_\_\_

\_\_\_\_\_

PROCEDURE	TYPE	MEDS / FEEDING AMOUNT	FREQUENCY SPECIFIC TIMES	RATE / FLOW
<b>Catheterization</b>				
<b>Feedings</b>	<input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube <input type="checkbox"/> NG-Tube <input type="checkbox"/> Special			
<b>Suctioning</b>	<input type="checkbox"/> Oropharynx <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Deep <input type="checkbox"/> Surface			
<b>Tracheostomy</b>	<input type="checkbox"/> Tube Replacement <input type="checkbox"/> Care (Cleaning)			
<b>CPT</b>				
<b>Oxygen</b>				
<b>Misting</b>				
<b>Nebulizer Tx</b>				
<b>Pulse Oximeter</b>				

Are any of the above procedures required for emergency care ?  YES  NO, **IF "YES"**, specify:

\_\_\_\_\_

List any procedures the student has been trained to perform \_\_\_\_\_

List any limitations / precautionary measures that should be considered; e.g. physical education, outdoor activities, transporting, lifting, moving, special devices / equipment : \_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION FOR MEDICATION / TREATMENT – Page 2**

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, diabetic reactions, etc.) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

There are no extraordinary emergency medical services available at school. Since only CPR and first aid are available until 911 arrive, is this adequate for student survival?  YES  NO, **IF "NO"**, specify:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Physician's Name (Printed)**  
\_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**  
\_\_\_\_\_

\_\_\_\_\_  
**Physician's Office Address**

\_\_\_\_\_  
**Physician's Telephone & Fax Numbers**

\_\_\_\_\_  
**Date Completed**

\*\*\*\*\*  
**This information will be obtained by School Board District Personnel**

**PARENTAL PERMISSION FOR MEDICATION / TREATMENT**  
(TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

I grant the principal or his / her designee the permission to assist or perform the administration of each medication or treatment / procedure to or for my child during the school day including when he/she is away from school property for official school events.

**NOTE:**

- **Medications must be supplied in the original container.** Ask the pharmacist to divided the medication into two completely labeled containers, providing one for home and one for school.
- Only medications / treatments authorized by a physician may be administered by school personnel.
- It is your responsibility to notify the school when there is a change in medication / treatment regimen.

\_\_\_\_\_  
Parent / Guardian Name (Printed)

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Work Phone Number (Include Ext. if any)

\_\_\_\_\_  
Other numbers where you may be reached during school hours (Include cellular phone and beeper)  
Form: #2240E  
Revised: 5/02



This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

**Part 1. Student Information (to be completed by student or parent).**

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Name of Parent/Guardian: \_\_\_\_\_  
 Person to Contact in Case of Emergency: \_\_\_\_\_  
 Relationship to Student: \_\_\_\_\_ Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: (\_\_\_\_) \_\_\_\_\_  
 Personal/Family Physician: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

**Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.**

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___	26. Have you ever become ill from exercising in the heat?	___	___
2. Do you have an ongoing chronic illness?	___	___	27. Do you cough, wheeze, or have trouble breathing during or after activity?	___	___
3. Have you ever been hospitalized overnight?	___	___	28. Do you have asthma?	___	___
4. Have you ever had surgery?	___	___	29. Do you have seasonal allergies that require medical treatment?	___	___
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	___	___	30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	___	___
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___	31. Have you had any problems with your eyes or vision?	___	___
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	___	___	32. Do you wear glasses, contacts, or protective eyewear?	___	___
8. Have you ever had a rash or hives develop during or after exercise?	___	___	33. Have you ever had a sprain, strain, or swelling after injury?	___	___
9. Have you ever passed out during or after exercise?	___	___	34. Have you broken or fractured any bones or dislocated any joints?	___	___
10. Have you ever been dizzy during or after exercise?	___	___	35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___
11. Have you ever had chest pain during or after exercise?	___	___	<i>If yes, check appropriate blank and explain below.</i>		
12. Do you get tired more quickly than your friends do during exercise?	___	___	___ Head	___ Elbow	___ Hip
13. Have you ever had racing of your heart or skipped heartbeats?	___	___	___ Neck	___ Forearm	___ Thigh
14. Have you had high blood pressure or high cholesterol?	___	___	___ Back	___ Wrist	___ Knee
15. Have you ever been told you have a heart murmur?	___	___	___ Chest	___ Hand	___ Shin/Calf
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___	___ Shoulder	___ Finger	___ Ankle
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___	___ Upper Arm	___ Foot	
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___	36. Do you want to weigh more or less than you do now?	___	___
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	___	___	37. Do you lose weight regularly to meet weight requirements for your sport?	___	___
20. Have you ever had a head injury or concussion?	___	___	38. Do you feel stressed out?	___	___
21. Have you ever been knocked out, become unconscious, or lost your memory?	___	___	39. Record the dates of your most recent immunizations (shots) for:		
22. Have you ever had a seizure?	___	___	Tetanus: _____ Measles: _____		
23. Do you have frequent or severe headaches?	___	___	Hepatitis B: _____ Chickenpox: _____		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___	<b>FEMALES ONLY (optional)</b>		
25. Have you ever had a stinger, burner, or pinched nerve?	___	___	40. When was your first menstrual period? _____		
			41. When was your most recent menstrual period? _____		
			42. How much time do you usually have from the start of one period to the start of another? _____		
			43. How many periods have you had in the last year? _____		
			44. What was the longest time between periods in the last year? _____		

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 11.8, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written below.

**Part 3. Physical Examination** (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician or certified advanced registered nurse practitioner).

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)

Visual Acuity: Right 20/\_\_\_\_ Left 20/\_\_\_\_ Corrected: Yes No Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
<b>MUSCULOSKELETAL</b>			
10. Neck	_____	_____	_____
11. Back	_____	_____	_____
12. Shoulder/Arm	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____

\* – station-based examination only

**ASSESSMENT OF EXAMINING PHYSICIAN/NURSE PRACTITIONER**

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

\_\_\_\_ Cleared without limitation.

\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_ Referred to \_\_\_\_\_ For: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician/Nurse Practitioner (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Physician/Nurse Practitioner: \_\_\_\_\_

**ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)**

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

\_\_\_\_ Cleared without limitation.

\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

*Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.*



# Consent and Release from Liability Certificate (Page 1 of 2)

This completed form must be kept on file by the school.

## Part 1. Student Acknowledgement and Release (to be signed by student).

I have read the (condensed) FHSAA Eligibility Rules printed on the reverse side of this "Consent and Release Certificate" and know of no reason why I am not eligible to represent my school in interscholastic athletic competition. If accepted as a representative, I agree to follow the rules of my school and FHSAA and to abide by their decisions. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved. Should I be 18 years of age or older, or should I be emancipated from my parent(s)/guardian(s), I hereby release and hold harmless my school, the schools against which it competes, the contest officials and FHSAA of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against FHSAA because of any accident or mishap involving my athletic participation. I hereby authorize the use or disclosure of my individually identifiable health information should treatment for illness or injury become necessary. **I hereby grant to FHSAA the right to review all records relevant to my athletic eligibility including, but not limited to, my records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness.** I hereby grant the released parties the right to photograph and/or videotape me and further to use my name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein. I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that I will no longer be eligible for participation in interscholastic athletics. **I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE.**

\_\_\_\_\_/\_\_\_\_\_  
 Name of Student (printed) Signature of Student Date

## Part 2. Parental/Guardian Consent, Acknowledgement and Release (to be completed and signed by all parents/guardians; where divorced or separated, parent/guardian with legal custody must sign).

A. I/we hereby give consent for child/ward to participate in the following interscholastic sports that I have **not marked out**:

Boys Sports:	Baseball	Basketball	Bowling	Cross Country	11-Man Tackle Football
	Golf	Lacrosse	Soccer	Swimming & Diving	Tennis
	Track & Field	Volleyball	Water Polo	Weightlifting	Wrestling
	Other sports added to this form by school: _____				
Girls Sports:	Basketball	Bowling	Cross Country	Flag Football	Golf
	Lacrosse	Soccer	Fast-Pitch Softball	Swimming & Diving	Tennis
	Track & Field	Volleyball	Water Polo	Weightlifting	
	Other sports added to this form by school: _____				

B. I/we understand that participation may necessitate an early dismissal from classes.

C. I/we know of, and acknowledge that my child/ward knows of, the risks involved in interscholastic athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I/we release and hold harmless my child's/ward's school, the schools against which it competes, the contest officials and FHSAA of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against the FHSAA because of any accident or mishap involving the athletic participation of my child/ward. I authorize emergency medical treatment for my child/ward should the need arise for such treatment while my child/ward is under the supervision of the school. I/we further hereby authorize the use or disclosure of my child's/ward's individually identifiable health information should treatment for illness or injury become necessary. **I/we consent to the disclosure, by my child's/ward's school, to the FHSAA, upon its request, of all records relevant to his/her athletic eligibility including, but not limited to, his/her records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness.** I/we grant the released parties the right to photograph and/or videotape my child/ward and further to use said child's/ward's name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein.

D. I/we understand that the authorizations and rights granted herein are voluntary and that I/we may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I/we understand that my/our child/ward will no longer be eligible for participation in interscholastic athletics.

E. Please check the appropriate box(es):

- My/our child/ward is covered under our family health insurance plan which has limits of not less than \$25,000.  
 Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_
- My/our child/ward is covered by his/her school's activities medical base insurance plan.
- I/we have purchased supplemental football insurance through my/our child's/ward's school.

**I/WE HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE.**

\_\_\_\_\_/\_\_\_\_\_  
 Name of Parent/Guardian (printed) Signature of Parent/Guardian Date

\_\_\_\_\_/\_\_\_\_\_  
 Name of Parent/Guardian (printed) Signature of Parent/Guardian Date



## Consent and Release from Liability Certificate (Page 2 of 2)

This completed form must be kept on file by the school.

### Attention Student

Your school is a member of the Florida High School Athletic Association (FHSAA) and follows established rules. To be eligible to represent your school in interscholastic athletics, you:

1. Must be regularly enrolled and in regular attendance at your school. If you are a home education student or attend a charter school that is not a member of the FHSAA, you must declare in writing your intention to participate in athletics to the school at which you are permitted to participate prior to the first day of practice. (FHSAA Bylaw 11.1)
2. Must enroll in school within 10 days of the beginning of **each semester** to be eligible during **that semester**. If not, you must make up all work missed and be in attendance a minimum of one day for each day missed due to late enrollment before your principal can declare you eligible. (FHSAA Bylaw 11.1)
3. Must maintain a cumulative 2.0 grade point average on a 4.0 unweighted scale through the end of the previous semester as required by Florida Statutes. This GPA must include all courses taken since you entered high school. For sixth-graders, seventh-graders and eighth-graders, you must have been regularly promoted from the previous grade, carry a normal class load, do satisfactory classroom work and maintain a satisfactory conduct record. (FHSAA Bylaw 11.2)
4. Must not have graduated from any high school or its equivalent. (FHSAA Bylaw 11.2)
5. Must participate at the school in which you first enroll, or at which you first take part in an athletic practice, at the beginning of the school year. (FHSAA Bylaw 11.3).
6. Must transfer from your previous school prior to the first day of practice and secure an "Application for Waiver of the Transfer Rule" signed by the principal of both your previous school and your new school. If you transfer on or after the first day of practice in a sport you cannot participate in that sport. If you transfer from a school at which you were ineligible because of disciplinary action or unsatisfactory conduct, you will be ineligible at your new school for one full semester. If you participate on a non-school team (i.e., AAU, American Legion, club setting, etc.) which is affiliated with or coached by a coach from a school other than the one you attend, or have attended, and then transfer to that school, it will be assumed you have been recruited to attend that school or transferred to that school for athletic reasons and you will be ineligible there for one year. If you transfer to a school that your coach has relocated to within the past year, it will be assumed you transferred to that school for athletic reasons and you will be ineligible there for one year. (FHSAA Bylaw 11.4).
7. Must not have **enrolled in the ninth grade for the first time** more than four school years ago. If you are a sixth-grader, seventh-grader or eighth-grader, you must not have participated in an earlier school year in the grade in which you are currently enrolled. (FHSAA Bylaw 11.5)
8. Must be less than 19 years 9 months old to participate in high school; 16 years 9 months old to participate in junior high school; and 15 years 9 months old to participate in middle school. On the day you reach one of these ages – regardless of when that day is – you become ineligible to participate on that level. (FHSAA Bylaw 11.6)
9. Must get signed permission to participate from your parents or guardian on a form provided by the school. (FHSAA Bylaw 11.7)
10. Must undergo a preparticipation physical evaluation and be certified as being physically fit for participation in interscholastic athletics. **The physical evaluation is valid for 365 calendar days from the date that it was administered** after which time you must successfully undergo another physical evaluation to continue your participation. (FHSAA Bylaw 11.8)
11. Must be an amateur. This means you must not accept money, gift or donation for participating in a sport, or use a name other than your own when participating. (FHSAA Bylaw 11.9)
12. Must not participate in an all-star contest in a sport prior to completing your high school eligibility in that sport. (FHSAA Bylaw 11.10)
13. Must display good sportsmanship and follow the rules of competition **before, during and after** every contest in which you participate. If not, you may be suspended from participation for a period of time. (FHSAA Bylaw 11.11)
14. Must not provide false information to your school or to the FHSAA to gain eligibility. (FHSAA Bylaw 11.12)

If you are declared or ruled ineligible for violation of any one or more of these rules and you do not agree with the decision, you have the right to request that your school file an appeal on your behalf. If you violate one or more of these guidelines because of an unforeseeable, unavoidable condition or event which places a severe burden upon you or your family and are declared or ruled ineligible because of that, you have the right to request that your school file a request for an undue hardship waiver of the rule or rules on your behalf. See your principal, athletic director or coach if you believe one of these two situations applies to you.



## GENERAL INFORMATION FORM

### STUDENT'S INFORMATION

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#1 Student's Name	Grade	Cell Phone	E-mail address
#2 Student's Name	Grade	Cell Phone	E-mail address
#3 Student's Name	Grade	Cell Phone	E-mail address
Home Address	City, State, Zip	Home Phone	

### PARENT'S INFORMATION

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Mother's Name	Cell Phone	Father's Name	Cell Phone
E-mail address	E-mail address		
Occupation	Work Phone	Occupation	Work Phone
Home Address (if other than above)	Home Address (if other than above)		
Street Address	Home Phone (if other than above)	Street Address	Home Phone (if other than above)
City, State, Zip	City, State, Zip		

### COMMITTEE INFORMATION

### CHAPERONE INFORMATION

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One committee per parent is **mandatory**. Please choose the committees you would like participate on.

#### MOTHER'S COMMITTEE CHOICES

- Chaperone Committee
  - I would like to be a **LEVEL II Chaperone**
- Uniform
- Meal
- Band Camp
- Field Crew
- Concession
- Fundraising
- Plume & Water
- Golf Tournament
- Truck
- Banquet
- Phone Tree
- Historian/Photographer
- 9<sup>th</sup> Grade
- 10<sup>th</sup> Grade
- 11<sup>th</sup> Grade
- 12<sup>th</sup> Grade
- Website

#### FATHER'S COMMITTEE CHOICES

- Chaperone Committee
  - I would like to be a **LEVEL II Chaperone**
- Uniform
- Meal
- Band Camp
- Field Crew
- Concession
- Fundraising
- Plume & Water
- Golf Tournament
- Truck
- Banquet
- Phone Tree
- Historian/Photographer
- 9<sup>th</sup> Grade
- 10<sup>th</sup> Grade
- 11<sup>th</sup> Grade
- 12<sup>th</sup> Grade
- Website

#### LEVEL I Clearance

If you wish to chaperone locally in the tri-county area, daily trips only. Sign up at [www.getinvolvedineducation.com](http://www.getinvolvedineducation.com)

#### LEVEL II Clearance

A Level II chaperone is able to go on over night trips and out of the tri-county area. This means that you must be finger printed by the **SCHOOL BOARD of BROWARD COUNTY ONLY!**

Once you have signed this form, you will be contacted and given a letter with directions to the **KC Wright Building** to get fingerprinted.