School of Skatin

EMERGENCY MEDICAL RELEASE

This form must contain only one child's name, and be the original notarized form.

A new notarized form is required when there is a change in legal guardianship.

Please Print Information

Child's Full Name:____ Birthdate:__________________________

Allergies:____

Medicines Routinely Taken:____

Name of Custodial Parent(s)/Legal Guardian(s):____

Address:____ ____________________ _________ _________
Street Address (number, apartment #, street) City State Zip Code

Home Telephone:_________________ Cell Telephone:_________________ Work Telephone:_________________

Home Telephone:_________________ Cell Telephone:_________________ Work Telephone:_________________

Family Physician's Name/Health Care Resource:____

Address:____ ____________________ _________ _________
Street Address (number, apartment #, street) City State Zip Code

Telephone:____

Hospital Preference: ____
Name City

Medical Insurance Company:____

Policy #:____ Expiration Date:_____________________

Emergency Contact (if custodial parent/guardian cannot be reached**)**:___________________________________

Address:____ ____________________ _________ _________
Street Address (number, apartment #, street) City State Zip Code

Home Telephone:_________________ Cell Telephone:_________________ Work Telephone:_________________

Sign in the presence of the Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child

____, in the event of an emergency at which time
(Child's Full Name)

I cannot be reached. I give consent to transport by ambulance if situation warrants it.

____

Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF ______________________

The foregoing instrument was acknowledged before me on__________________________________ _______20_____
(Month) (Day) (Year)

by____, who is personally known to me or who has
(Name of Affiant)

Produced____as identification. SEAL OF NOTARY
(Type of Identification)

Signed:____ (*Signature of Notary)*

FC-0003 Samples (7/30/13)

Food Experience Permission Form

I give permission for my child __________________________________ to participate in food related activities.

Please check one of the following:
___________My child DOES NOT have a food allergy or dietary restriction.
___________My child DOES have a food allergy or dietary restriction.

He or she may participate, but may not eat or handle the following items (please list below)
____
____
____

My child DOES have a food allergy or dietary restriction. He or she may not participate in activities.

__________________________________ ____________________________
Parent Signature   Date

Child's Enrollement Record

DIRECTOR'S USE ONLY

Date enrolled____________

Skateboarding Camp Program

Child's full legal name____
First *Middle* *Last*

Sex __________ **Birth Date**______________________________

Child's preferred name/nickname____________________________________

Address____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Who has legal custody______________________________ Relationship__________________

Address____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Home Phone______________________ Cell Phone______________________

Parent's name____

Home Phone______________________ Cell Phone______________________

Home address____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Place of employment____

Address of employer____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Telephone______________________ Ext__________

Parent's name____

Home Phone______________________ Cell Phone______________________

Home address____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Place of employment____

Address of employer____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Telephone______________________ Ext__________

The child will be released only to the person(s) authorized, or in the manner authorized, in writing, by the custodial parent(s) or legal guardian(s). The following person must be someone other than the custodial parent(s) or legal guardian(s) and is authorized to remove the child from the facility in case of illness, accident, or emergency, **if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:**

Name____

Home Phone______________________ Cell Phone______________________

Address____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Name____

Home Phone______________________ Cell Phone______________________

Address____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

CONTINUED

Child's physician/healthresource____
Telephone Number____
Address:____
Street Address (number, apartment #, street) City State Zip Code
Hospital preference:____
Name of Dentist:________________________________Telephone:_________________________
Address:____
Street Address (number, apartment #, street) City State Zip Code

MISCELLANEOUS INFORMATION

List all known allergies____
List all identifying scars, birthmarks, skin discolorations _______________________________________
Special medical or dietary needs of child ____
List any areas of concern____

My signature below verifies that:

I give permission to consult the child's physician/health resource listed above in case of emergency if parent/guardian cannot be reached.

I was notified that child is to bring a non-perishable lunch, refillable water bottle and snack daily Helmets are required to be worn daily in order to participate.
All children under the age of 10 are required to wear knee pads, elbow pads and wrist guards.

My child is permitted to check him or herself out from the group? ☐ Yes, Time_______ ☐ No
Child's School Current Grade (as of 8/17)_____________________________
Parent's E-mail Address____

Any adult other than parent/guardian listed on this form has your permission to remove your child from our care, and might be called if needed.
Name___________________________ Relationship to Child______________ Phone #_______________
Name___________________________ Relationship to Child______________ Phone #_______________

Parental Acknowledgment & Transportation Agreement

By signing this form: (1) We have your permission to put sun screen on your child; sun screen is not provided. (2) Your elementary camp participant has permission to watch G and PG rated movies and/or your middle school camp participant has permission to watch G, PG and rated movies during any program. (3) I give permission for my child to participate in Transportation on the School of Skatin "SK8 Bus" for all Field Trips related to Summer, Fall Winter and Spring programs, if applicable. I acknowledge: All camper are required to wear a helmet at all times during participation in the camp, campers 10 and under are required to wear Knee pads, Elbow pads, wrist guards. All campers must bring a non-perishable lunch daily and a refillable water bottle.

____
Signature of Custodial Parent or Legal Guardian Date

School of Skatin Media Release Form

Dear Parent,

Please be advised during Summer Skateboarding Camp your child may be photographed, videoed at the various skateparks or School of Skatin activities. With your consent the photos, video may be reproduced or release for the use in the School of Skatin advertising such as: Instagram, Facebook, television, internet, flyers, brochures newspaper ect.

____ ______________________

Childs Name (first and last) Date:

My child photo/video may be reproduced and used for media.

____ __________________

Parent Signature Date: