

## PERMISSION TO PARTICIPATE IN OVERNIGHT FIELD TRIP

This permission form has been signed only after understanding and considering the following:

1. Trip Planned: 2:30PM-Thursday, January 17, 2019, depart for Walt Disney World. Stay at the Port Orleans Riverside Resort. Park days and workshop at Walt Disney World. Return to Walton at 5:00PM on Monday, January 21, 2019.
2. Purpose(s) of Trip: The purpose of the trip is to gain knowledge as an orchestra student about sightreading and being a studio musician through participating in a workshop at Walt Disney World. This trip is a supplement to the curriculum.
3. Supervision: Dr. Holbrook, Mrs. Grimes, a Walton administrator, and parent chaperones will all supervise students. We will travel with at least a ratio of 1 adultx 12.5 students
4. Transportation: Charter bus transportation. Walt Disney World transportation inside of the parks
5. Requirements: Students must be in good academic standing and have no severe disciplinary infractions. Students must have attended all orchestra concerts prior to the trip.
6. Expectation and Instructions: Students are expected to adhere to all Cobb County, Walton, and Walt Disney World instructions. Students are not allowed in the hotel pool.

### Student Information

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
In case of emergency, notify: \_\_\_\_\_ Phone: \_\_\_\_\_

### Insurance Information

Company Providing Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Group Number: \_\_\_\_\_

### Medical Information

Family Physician: \_\_\_\_\_ **Phone:** \_\_\_\_\_  
Immunizations: \_\_\_\_\_

Does the student need to take medication?  Yes  No If so, what medication? \_\_\_\_\_

Previous operations or serious illnesses: \_\_\_\_\_

Special medical conditions: \_\_\_\_\_

Allergies?  Yes  No If yes, please identify allergy:  Medication  Food  Stinging Insects  Other

Please identify: \_\_\_\_\_

Dietary Restrictions: \_\_\_\_\_

### Release

I understand the above expectations/special instructions and acknowledge that my child is expected to comply with them. Further, I have instructed my child to comply with them as well as other directions given by trip supervisors.

The District does have an indemnity plan pursuant to O.C.G.A. § 20-2-1090 that may or may not apply relative to the trip. Even if the plan covers some or all of the trip, the coverage amounts may not cover all injuries. I understand that as a parent I have the option of, and am encouraged to, purchase student insurance coverage either through the student accident insurance offered by the District or through my own insurance carrier.

I (Parent/Guardian Name-PLEASE PRINT): \_\_\_\_\_ acknowledge that participation in the field trip described above is not mandatory and that a quality alternative instructional experience will be provided to those students choosing not to participate.

If any emergency medical procedures or treatment are required during the trip, I consent to the trip supervisor(s) taking, arranging for or consenting to the procedures or treatment in his/her or their discretion.

I agree to release, indemnify, and hold harmless or reimburse the Cobb County School District (District), its Board of Education, and its members, employees, agents, representatives, successors or assignees, as well as its approved adult trip supervisors ("District Indemnitees") from and forever promise not to sue them on any and all claims, demands, rights, causes of action, liabilities, losses, damages, costs and expenses (including reasonable attorneys' fees), whether known or unknown, that I, any other parent or guardian of the above-named student, the student or any other successor or assignee may have or may allege to have against the District Indemnitees or which may be brought against the District Indemnitees arising out of or in any manner relating to the student's participation in the field trips, including but not limited any losses, damages or injuries or to the rendering of emergency medical procedures or treatment.

**NOTE:** This form must be signed by student if the student is 18 years of age or older.

\_\_\_\_\_  
**Name of Parent/Guardian (PLEASE PRINT)**

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

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