

AUGUST 26, 2019 – JUNE 12, 2020

This **YEARLY PERMISSION FORM** applies to all regular off-campus weekday/weekend activities including overnight stays for the Spiritual Life Retreat. A separate form may be required for out-of-state/country trips (Sophomore/ Senior).

STUDENT AND CONTACTS

I, as student named below, desire to participate in the activities of Plymouth Christian Academy, and promise to follow the instructions of the PCA Staff and to respect the rights of others. I promise not to bring or use alcohol, tobacco, illegal drugs, or fireworks. I agree, if I violate this promise, my Parent(s)/Guardian(s) may be notified and I may be sent home at my expense, before the activity is over. The duration of this agreement lasts for the school year designated above.

STUDENT NAME- please print- LAST _____ **FIRST:** _____

STUDENT SIGNATURE _____ **Birthdate** _____ **Grade** _____

1ST EMERGENCY CONTACT (PARENT)

Father: Home #: _____ Cell #: _____ Work #: _____

Mother: Home #: _____ Cell #: _____ Work #: _____

2ND EMERGENCY CONTACT NAME _____

Name/Relationship: _____ **Phone:** _____

Date: _____

HEALTHCARE INFORMATION

Personal Physician: _____ **Phone:** _____

Date of LAST TETANUS SHOT: _____

MEDICATION DIRECTIVE FOR OFF-CAMPUS or OVERNIGHT EXCURSIONS

PRESCRIPTION MEDICATIONS must be in the ORIGINAL container with ORIGINAL pharmacy labeling, and be given to the designated chaperone BEFORE departure.

1) a) My student is currently taking a **PRESCRIPTION** medication: No Yes

If YES, List Name & Required Dosage of each prescription:

1) _____ Permission to self-dispense No Yes

2) _____ Permission to self-dispense No Yes

3) _____ Permission to self-dispense No Yes

2) Has **allergies:** No Yes If yes, explain: _____

3) Has **special** medical/medication difficulties: No Yes. If YES, explain: _____

OVER-THE-COUNTER MEDICATIONS-A student may possess and self-administer his/her own "OTC" medication. However, if needed, I/we, as parent(s)/guardian(s), **authorize the sponsors** to give my/our student the **following:**

Acetaminophen (Non-aspirin pain reliever, i.e. **Tylenol**) Dosage: _____

Ibuprofen (i.e. **Motrin, Aleve, Midol**) Dosage: _____

Antihistamine (i.e. **Benadryl, Sudafed**) Dosage: _____

Dimenhydrinate (i.e. **Dramamine**) Dosage: _____

Other OTC Medication: _____ Dosage: _____

NO OTC medications.

Additional information _____

NOTARIZATION – Parent must sign in presence of Notary

Signature Authorization, including Liability Waiver and Limited Purpose Power of Attorney (see reverse)

PARENT/GUARDIAN SIGNATURE: _____

NOTARY: _____

Date: _____

Information on Reverse

LIABILITY WAIVER

I/we acknowledge that participation in PCA activities involves risk to my/our son/daughter and to me/us and may result in various types of injury including, but not limited to, the following: sickness, bodily injury, death, emotional injury, personal injury, property damage and financial damage. In consideration for the opportunity to participate in PCA activities, I/we acknowledge and accept the risks of injury associated with participation in and transportation to and from the activities. I/We accept personal financial responsibility for any injury or other loss sustained during activities or during transportation to and from activities, as well as for any medical treatment rendered that is authorized by PCA, employees, volunteers, or any other representatives (collectively referred to hereinafter as the "Activity Sponsor"). Further, I/we release and promise to indemnify, defend, and hold harmless the Activity Sponsor for any injury arising directly or indirectly out of activities or transportation to and from activities, whether such injury arises out of the negligence of the Activity Sponsor, the Participant, or otherwise.

If a dispute over this agreement or any claim for damages arises, I/we agree to resolve the matter through a mutually acceptable alternative dispute resolution process. If I/we and the Activity Sponsor cannot agree upon such a process, the dispute will be submitted to a three-member arbitration panel for resolution pursuant to the rules of the American Arbitration Association.

I/We, hereby grant the named student (our son/daughter) my/our permission to attend and participate in the activities off and on-campus (i.e. class, grade or school sponsored field trips or activities) during and after school hours. I/We do hereby give permission for our son/daughter to be transported by PCA bus with those in whose care the minor has been entrusted while attending and participating in activities sponsored by Plymouth Christian Academy.

LIMITED PURPOSE POWER OF ATTORNEY

Consent to Treatment of a Minor:

- A. As parents/guardian, I/we appoint and delegate the PCA Staff the power to consent on our behalf to all emergency treatment and/or medical/dental care (except elective surgery) for named STUDENT, as determined to be necessary or desirable by the attending physician/dentist at his/her office or hospital.
 - B. The Power of Attorney shall continue for the duration of the trip or until revoked by the parents/guardian. Physicians, hospital medical staff or dentist may assume and rely that this authorization is currently in effect unless notified.
 - C. The parents/guardian certify that they have read this Power of Attorney (or had it read to them), and that they understand this Power of Attorney.
 - D. In the event of medical or dental treatment, parents/guardians are completely responsible for any necessary treatment cost incurred.
 - E. If there are any religious or personal objections that do not allow your son or daughter to receive certain types of medical or dental treatment, you must give a signed written statement stating your position.
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