

TAMPA ELITE SPORTS ACADEMY

PERMISSION AUTHORIZATION FOR FIELD TRIP, FROM SCHOOL TRANSPORT AND EMERGENCY EVACUATION

Staff may plan special field trips for children away from the center. These trips are carefully arranged in advance and shall be supervised by an adequate number of staff members. You will always receive advance notice of all field trips. Please indicate that we have permission to take your child, _____ on field trips by signing below.

Parent Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

For emergency purposes, we have permission to evacuate the premises. Our emergency evacuation site is Wendy's on Sheldon. We also have permission to transport your child from their elementary school to our facility.

Parent Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

STUDENT/ PARTICIPANT PLEDGE

I PROMISE:

1. To follow all safety rules and directions in the classroom, the fields, play area, on the van/bus and on field trips
2. To cooperate with staff and my teammates and respect their space and belongings. I understand this means no bullying, yelling or physical contact that may hurt another person.
3. To use appropriate language at all times use a quiet voice in the classroom and in the van/bus and listen when someone else is speaking.
4. To be a team player and show good sportsmanship behavior.
5. To be respectful of facility equipment.

REGARDING FIELD TRIPS:

I understand that if I act in a way that may endanger my friends and/or myself, or have to be continually reminded of the rules I may not be allowed to attend the next field trip.

I have read this pledge together with my parent/guardian and understand the rules and guidelines.

Child's Signature: _____ **Date:** _____

Parent/guardian Signature: _____ **Date:** _____

PARTICIPATION REGISTRATION AND CONSENT FORM

Childs Name: _____ Age _____ Sex _____ DOB: ____/____/____

Address: _____ City _____ Zip _____

School Attending: _____ Grade _____ Date Enrolled at T.E.S.A _____

Custodial Parent (Circle One): Mother Joint Father

Mothers Name: _____ Fathers Name _____

Home Phone: _____ Home Phone: _____

Employment: _____ Employment: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

PERSONS AUTHORIZED TO REMOVE CHILD (IDENTIFICATION REQUIRED)

- 1. _____

NAME	RELATIONSHIP	PHONE
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- 2. _____

NAME	RELATIONSHIP	PHONE
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- 3. _____

NAME	RELATIONSHIP	PHONE
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ALTERNATE NUTRITION PLAN

I understand and approve the use of the alternate nutrition plan. I agree to provide the following meals and/or snacks to meet my child's nutritional and dietary needs. Indicate special dietary requirements: _____

(Mark **P** for parent provides or **C** for Center Provides)

Breakfast	AM Snack	Noon Meal	PM Snack	Dinner	Snack	Evening
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HILLSBOROUGH COUNTY ORDINANCE requires that parents must receive a copy of the "KNOW YOUR CHILD'S DAY CARE FACILITY BROCHURE/FDCH BROCHURE" and the parents are notified in writing of the "DISCIPLINARY PRACTICES" used by the childcare facility. The parent's/legal guardian's signature certifies receipt of the child care facility brochure/fdch brochure discipline policies, agreement of the alternate nutrition plan, and all of the information on this form is complete and accurate.

Signature of parent or legal guardian

STATEMENT OF CONSENT BY PARENT

Parents are responsible for the actions and behavior of their child while participating in Tampa Elite Sports Academy programs and activities. I understand that my child is subject to the Tampa Elite Sports Academy disciplinary policies while participating in programs and activities. In consideration of allowing my child to participate in Tampa Elite Sports Academy programs and facilities, I hereby hold and save Tampa Elite Sports Academy harmless from and against any and all liability, loss, claim, suit, damage, charge or expense which Tampa Elite Sports Academy, its employees or agents may suffer, sustain, incur or in any way subjected to an account of death of or injury to my child arising out of , resulting from, or in any way connected with my child participating in Tampa Elite Sports Academy recreation or sports programs or using Tampa Elite Sports Academy facilities.

I understand that if my child has a contagious condition, e.g. head lice, chicken pox, etc. I will not bring my child to the facility until he or she is no longer contagious anymore. I agree to abide by this for the protection of my child as well as other children and staff members at the facility.

I give my permission for my child to participate in any activities programmed by Tampa Elite Sports Academy. I understand some activities may involve supervised travel and that I will be notified prior to the trip for additional consent.

I give permission for my child to watch "PG" rated movies. Yes_____ No_____

I give permission for my child to watch "PG-13" rated movies. Yes_____ No_____

Signed:_____ **Date:**_____

Relationship to participant:_____

Participants Signature:_____

Medical Alert Information (i.e., Allergies medical and/or handicapping conditions): _____

List any additional information which would be beneficial for the childcare staff to know about your child:

Preferred Physician: _____

Address: _____ Phone: _____

Preferred Hospital: _____

Note: Immunization Record Should accompany child.

EMERGENCY CONTACT (OTHER THAN PARENTS)

- | | | | |
|----|-------|--------------|-------|
| 1. | _____ | _____ | _____ |
| | NAME | RELATIONSHIP | PHONE |
| 2. | _____ | _____ | _____ |
| | NAME | RELATIONSHIP | PHONE |

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____, Should become ill or injured at

Tampa Elite Sports Academy, I understand that the facility will: (1) Contact me immediately and (2) contact the person(s) I have designated if I cannot be reached.

Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and arrange for immediate medical treatment.

The physician and /or medical facility are authorized to administer emergency medical treatment necessary to ensure the safety of my child.

I will accept responsibility for payment of medical services rendered.

_____	_____	_____
SIGNATURE	RELATIONSHIP	DATE

Sworn and subscribed before me this _____, day of _____, 20____

Notary Public, State of Florida-At Large.

My Commission Expires: _____

_____ Who is personally known to me

_____ Who has/have produced identification: _____

