

South Broward High School



THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Off-Campus Authorization Form For Teachers

Date Submitted: ____/____/____

Sponsors Name: _____

Dead line for returning form to sponsors: ____/____/____

Student Name: _____ Telephone: _____

Field Trip Destination: _____

Off Campus Activity Start Date & Time: ____/____/____ ____:____

Off Campus Activity End Date & Time: ____/____/____ ____:____

Period(s) missed: 1st 2nd 3rd 4th 5th 6th 7th 8th

Teachers: Your signature below indicates that you acknowledge that this student has requested to participate in an off-campus activity that would possibly require him/her to be absent from your class on the above date.

TEACHERS: DO NOT SIGN THIS FORM WITHOUT ADMINISTRATIVE APPROVAL

Period	Teacher Signature	Grade	Subject
1			
2			
3			
4			
5			
6			
7			
8			

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Single Field Trip Parent/Legal Guardian Authorization Form
High School - Magnet Program - Center

Student Name: _____ Telephone: _____

For Single field trips, transportation to and from events may vary.

- ❖ No motorcycles/scooters/mopeds permitted as transportation.
- ❖ Maximum capacity is one (1) person per seat belt.

1. I authorize my student to: Ride with Staff: ____ Ride with Another Student: ____ Act. Bus: ____ Airplane ____
2. I authorize my student to: Drive Own Car: ____ Drive Family Car: ____ Charter Bus: ____ Dist. Bus: ____
3. Drive car and carry passengers including fellow students: Rental Car/Van ____ Walking ____

Field Trip Destination: _____

Departure Date & Time: ____/____/____ ____: ____

Return Date & Time: ____/____/____ ____: ____

Deadline for field trip forms to be turned in: ____/____/____

EMERGENCY CONTACT

In case of an emergency, I may be reached at:

Name: _____ Telephone: _____

In the event I cannot be reached, please contact:

Name: _____ Telephone: _____

HEALTH/ACCIDENT INSURANCE

My student is covered by twenty-four (24) hour student accident insurance or family insurance:

Insurance Company: _____

Policy Number: _____ or I've attached a photo copy of my family insurance identification card.

____ I do not have insurance; however, I will pay any and all medical bills for emergency care of my student.

School Year: 2019/2020

Signature of Parent or Guardian/Date