FLORIDA GULF COAST UNIVERSITY
FIELD TRIP LIABILITY RELEASE AND EMERGENCY DATA FORM
(Please Complete Both Front and back of Form)

I, _____ , realize that some of the class meetings in this course are off campus field trips for which I must accept the transportation provided by the University or arrange my own transportation. I also realize that such field trips, although well-supervised, involve risks of accidents not encountered in the classroom. I hereby assume the risk of such potential accidents, as well as transportation-related accidents and agree to hold Florida Gulf Coast University Board of Trustees, its officers, faculty and staff harmless from injuries, damages, liability or losses resulting therefrom, as well as any injuries, damages or losses resulting from transportation provided by the University or my own transportation, to and from field trip sites.

Additionally, I realize that field trips themselves, both on and off campus, involve risks not encountered in the classroom. In the event of an emergency, the person named below is authorized to act on my behalf in the event that I am incapacitated. In the event the person named below cannot be reached, I authorize Florida Gulf Coast University faculty and/or staff to arrange emergency medical treatment on my behalf. On the reverse side of this form, I have listed any medical conditions that should be considered in the event that I must receive emergency treatment.

Emergency Contact Person: _____
Relationship to Me: _____
Telephone Numbers: _____
Address: _____
_____
Course: _____

Name of Student (Please Print):_____

Signature of Student **:** _____
(or parent if you are under 18 years of age) Date: _____

NOTE: Because class activities may occur on the buses, student understands that they will not receive credit for this trip unless the student travels on the bus. _____
_____
_____

MEDICAL EMERGENCY INFORMATION

Name: _____
Telephone Number: _____
Insurance Carrier: _____
Policy #/Group # _____ _____
Address: _____
_____
_____

The following are medical or disabling conditions that should be considered in the event that I must be treated for an accident or medical emergency. (Please list such things as allergies to animals, plants, or medications or any other information that might affect medical treatment.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand that I (or my parent(s)) will be financially responsible for any expenses incurred related to my medical treatment.

I, the undersigned, have provided complete information above with the understanding that it will be shared with others only on a medical need-to-know basis.

_____ _____
Signature Date