



Calgary Board
of Education

Consent of Parent or Guardian and “Acknowledgement of Risk” for “A” and “B” Off-Site Activity/ies Risk and Insurance Management

PLEASE READ CAREFULLY

STUDENT NAME: _____

SCHOOL: WILLIAM ABERHART HIGH SCHOOL

1. Select either (i) or (ii)

- (i) ☐ My child will be given the opportunity to participate in the following program or activity: (please specify program)

William Aberhart 2016 Junior Football Program

a) Name of the Service Provider: Calgary Board Of Education

b) Location: William Aberhart High School

c) Date: June 16, 2016 - Dec 1, 2016

d) Teacher in Charge: M. Mohammed

- (ii) ☐ My child will be given the opportunity to participate in the following series of off-site activities for the following program.
(please specify program) _____

***SEE THE ATTACHED LIST FOR ACTIVITIES, DATE, LOCATION, SERVICE PROVIDER AND TEACHER IN CHARGE.**

2. The Board will make every reasonable effort to ascertain that:
- The supervisors and staff of the Service Provider are fully trained and qualified.
 - The students who undertake the program or activities will be adequately supervised.
 - The location and/or facilities meet the applicable health and safety standards.
 - Any equipment made available by the Service provider or used in the activity has been inspected and is deemed to be appropriate, safe, and well maintained.
 - The Service Provider has taken all reasonable steps to ensure that any animal(s) involved in the activity are safe.

CONSENT AND ACKNOWLEDGEMENT OF RISK

3. ***I/We acknowledge the existence of known hazards and the potential for unknown hazards inherent in the above program or activity(ies) and voluntarily assume such risks, which may result in any manner of injury, illness and/or death to my child, as a result of the following:***

ENTIRE TRIP: SLIPS, TRIPS AND FALLS; GETTING LOST OR SEPARATED FROM GROUP; PRE-EXSISTING MEDICAL CONDITIONS.

SPORT : INHERENT RISKS OF ACTIVITY, SPORTS SPECIFIC INJURIES;

TRAVEL: MECHANICAL FAILURE; DELAY; ACCIDENTS OR COLLISIONS; POOR ROAD CONDITIONS.

EATING: T-I-C REVIEW STUDENT MEDICAL FORMS AND BE AWARE OF STUDENTS THAT HAVE ALLERGIES. TEACHER(S) WITH CURRENT FIRST AID CERTIFICATE IS/ARE ON THE TRIP.

4. The following means of transportation **School Bus or approved bus carrier** will be provided by: **WILLIAM ABERHART HIGH SCHOOL**

5. I accept this mode of transportation for this activity: ☒ Yes ☐ No

OR

I permit my child to use alternate means of transportation, as identified:

☐ Yes ☒ No

Other: _____ (please specify)

6. I am satisfied that I have been informed of my right to obtain as much information about this program, or activity as I feel necessary, including information beyond that provided to me by the school or Board to the extent that I require and am not, in any way, relying solely upon information provided by the Calgary Board of Education respecting the nature and extent of the risks and hazards associated with the program or activity.
7. I freely and voluntarily assume the risks and hazards inherent in the nature of the program or activity and understand and acknowledge that my child, as a participant, may suffer personal and potentially serious injury due to an unforeseeable or fortuitous event.
8. My child has been informed that he/she is to abide by the rules and regulations including directions and instructions from the school's teachers, instructors, and supervisors as imposed on students while participating in the program or activities. This shall include his/her participation in all of the introductory sessions and meet all prerequisites prior to his/her participation in the activity or program.
9. In the event that my child fails to abide by the rules and regulations imposed on the student while participating in the program or activities, disciplinary action may either require that he/she not participate in the program or activity, or that I will be contacted to have him/her picked up, unless I have permitted my child to pursue alternate means of transportation as identified herein.
10. I acknowledge that it is my responsibility to advise the Board of any medical or health concerns of my child which may affect his/her participation in the stated program or activity.
11. I consent that the Board, through its employees, agents, and officers at the school may secure such medical advice and services as those individuals, in their sole discretion, may deem necessary for my child's health and safety, and that I shall be financially responsible for such advice and services.

Based upon my understanding of the activity(ies) and the hazards identified above, I give my child permission to participate in this activities(ies)

Date: _____ Name _____ Signature: _____
(Please Print) (Parent/Guardian)

IMPORTANT – MEDICAL INFORMATION

Health Information: (Teacher-in-Charge will have a photocopy of this information during the Off-Site Activity/ies to address health and medical needs including emergencies and may share this information with others as deemed necessary.)

MUST BE COMPLETED BY A PARENT OR GUARDIAN

Activity: William Aberhart Junior Football

Date(s) June 2016 - Dec 2016

Student Name: _____ Date of Birth (Yr/M/D): _____

Allergies:	Does your child have Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please specify below.
Drug Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insect Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Conditions

Is your child under any form of treatment for an illness, condition or injury? (including Asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please elaborate. Include activities to be restricted or modified.
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Please fill out the medication names and details for administering them: (if more space is required please attach additional information)

NAME OF MEDICATION	REASON (OPTIONAL)	DOSAGE	HOW OFTEN?	TIME OF DAY

Medication storage Requirements: _____

Medical Treatment Restrictions (if any) e.g. blood transfusions: _____

Dietary Restrictions (if any): _____

Additional Instructions/Information: _____

Emergency Contact 1: Name: _____ Home: _____ Mobile: _____ Work: _____	Emergency Contact 2: Name: _____ Home: _____ Mobile: _____ Work: _____
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The above medical information is accurate to the best of my knowledge. I hereby give CBE Staff and representatives permission to assist and administer the above medications. This information is consistent with the CBE Request for Assistance to Administer Medication Form.

Signature: _____ (Parent/Guardian)

Name: _____ (Please Print)

Personal information is collected under the authority of Alberta's Freedom of Information and Protection of Privacy Act (FOIP) and the School Act. This information will be used to see if the candidate(s) meet the criteria and will be treated in accordance with the privacy protection provisions of the FOIP Act. If you have any questions about the collection, contact your School Principal or Corporate Risk Management at 403-817-7407.