

# Robert F. Munroe Day School Permission Form

## READ CAREFULLY BEFORE SIGNING

In consideration for my child's participation in the MUNROE EDUCATION, NORMAL SCHOOL ACTIVITIES, ATHLETIC, AND EXTRACURRICULAR ACTIVITIES ("Program"), I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE the Program, the school Munroe, the Board of Trustees, and their respective employees, outside contractors, agents, representatives and volunteers (hereinafter referred to as "RELEASEES") from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by my child, or to any property belonging to me, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES or otherwise, while participating in the Program, or while in, on or upon the premises where the Program is being conducted.

### Program Activities may include, but are not limited to the following:

- AFTER-SCHOOL OR SCHOOL DAY ACADEMIC ENRICHMENT
- EDUCATIONAL AND CLASSROOM EXPERIENCES
- AFTER-SCHOOL ATHLETIC ENRICHMENT
- TRANSPORTATION TO OFF-SITE PROGRAM ACTIVITIES (INCLUDING SPORTING EVENTS)
- OUT OF TOWN FIELD TRIPS
- OFF-SITE ELECTIVE CLASSES
- OUTDOOR/FIELD ACTIVITIES INCLUSIVE BUT NOT LIMITED TO RUNNING, JUMPING, STRETCHING AND LONG DISTANCE WALKING
- OVERNIGHT STAYS
- INTERACTIVE CLASSROOM INSTRUCTION
- VISITS TO SITES OFF CAMPUS

## IDENTIFICATION AND ACKNOWLEDGMENT OF RISK

**Any disease may be contagious and it may be impossible to avoid exposure to any number of potentially harmful infections. By attending Robert F Munroe Day School, you agree to abide by the procedures established by the school to protect attendees and staff, and you voluntarily assume the risk that you and/or your family may be exposed to or infected by any disease either at the school, school activities, transportation, at athletic events, or in the nursery at school. You agree to assume all the risks of attendance and participation for you and your family, and you waive any liability against the school and any other parties.**

**I am fully aware of the risks and potential hazards connected with participating in the Program, including but not limited to, the risk of loss of personal property from theft, injuries associated with WALKING, RUNNING, ATHLETIC ACTIVITIES, TRANSPORTATION, INSTRUCTION, and other injuries that may not be foreseeable and I hereby elect to voluntarily participate in the Program and engage in such activity knowing that the activity may be hazardous to my child and my property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE OR PERSONAL INJURY, that may be sustained by my child, or any loss or damage to property owned by me, as a result of my child being engaged in such an activity, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEES or otherwise.**

## ACKNOWLEDGMENT OF GOOD PHYSICAL CONDITION

I further acknowledge that my child is in good physical condition and I do not know of any medical or physical condition or other reason that my child should not participate in the Program or which could interfere with my child's safety in such Program, or else I am willing to assume—and bear the cost of— all risks that may be created, directly or indirectly, by any such condition. My child's participation in any Program activity is purely voluntary, and I elect to have my child participate in spite of the risks and known or unknown dangers associated with Program activities.

## CONSENT TO PHOTOGRAPHY

I further hereby authorize Munroe to photograph and/or video record my child during the Program, and use or distribute any picture or video related to Program activities that my child is depicted in. I also authorize use of these materials for publication in a brochure, on the school's websites, or other Munroe promotional material. They may also be distributed to other Program participants, including but not limited to a Program group picture of all participants.

# Robert F. Munroe Day School Permission Form

## RELEASE AND WAIVER OF LIABILITY

I HEREBY EXPRESSLY RECOGNIZE AND ASSUME ALL RISKS ASSOCIATED WITH MY CHILD'S PARTICIPATION IN THE PROGRAM AND VOLUNTARILY RELEASE, WAIVE, DISCHARGE, COVENANT NOT TO SUE AND HOLD HARMLESS THE RELEASEES. I AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEES from any loss, liability, damage or costs, including court costs and attorneys' fees, that may incur due to my child's participation in the Program WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEES or otherwise. It is my express intent that this Participant Release, Consent and Waiver of Liability shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this Participant Release, Consent and Waiver of Liability shall be construed in accordance with the laws of the State of Florida.

IN SIGNING THIS PARTICIPANT RELEASE, CONSENT AND WAIVER OF LIABILITY, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducement, apart from the foregoing written agreement, have been made; I am at least eighteen (18) years of age and fully competent and I am the parent or guardian of the child participant, and I execute this Participant Release, Consent and Waiver of Liability for full, adequate and complete consideration, fully intending to be bound by same.

## CONSENT TO MEDICAL TREATMENT

During the Program, I hereby give permission for the Program staff to administer appropriate medical attention to my child in the event of any accident, illness, or injury, including non-prescription medications or any medications my child brings to camp in original containers with dosage instructions that is provided to Program staff. In the event of an emergency, 911 will be called and I will be responsible for any and all costs of medical coverage and treatment provided not covered by my child's insurance.

Printed Student Name: \_\_\_\_\_

Student Current Grade: \_\_\_\_\_

Printed Parent or Guardian Name: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Pick-up Parent Cell Phone \_\_\_\_\_

Pick-up Parent Email \_\_\_\_\_

Date: \_\_\_\_\_

Emergency Contact Cell Phone Number: \_\_\_\_\_

Emergency Contact Email: \_\_\_\_\_

Any Known Allergies: \_\_\_\_\_



# ROBERT F. MUNROE DAY SCHOOL

## PERSONAL DATA

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Parent/Guardian with whom the student lives: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if different from student): \_\_\_\_\_

Email Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if different from student): \_\_\_\_\_

Email Address: \_\_\_\_\_

The following people may be called in case of emergency if a parent cannot be reached (include name and phone number):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_



## Robert F. Munroe Day School Acknowledgment Form

I acknowledge and confirm that I have been given access to the online Munroe 2023-2024 Student Handbook via the school website.

I also acknowledge and confirm that it is my responsibility as the parent or guardian to read the handbook, be familiar with the handbook and ensure that my student(s) are in compliance with the handbook at all times including dress code.

I also acknowledge and confirm that, as situations arise the school may be required to make changes or updates to the handbook and will make reasonable efforts to notify parents if and when that happens but my students are still expected to be in compliance at all times.

Parent/Guardian Signature: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_



ROBERT F. MUNROE  
DAY SCHOOL  
*Est. 1862*

### Student Transportation Agreement

The following applies to all students riding in the school transportation system, either buses, vans, or cars, referred to in this document collectively as buses and bus stop.

Students must abide by the following rules:

1. Before crossing the roadway, ensure the road is clear in both directions. Do not depend entirely on the bus stop arm to control traffic.
2. Stay in your seat at all times. Students must wear seat belts at all times.
3. Talk quietly. Do not talk when directed by the driver, when approaching railroad crossings, accidents, or when sirens are heard. Do not talk or shout out the windows.
4. Keep all body parts inside the windows.
5. Do not throw waste paper or other rubbish on the floor or otherwise litter, mark, deface, or damage the vehicles. In addition, littering from the bus or van is prohibited. This includes, but is not limited to, spitting.
6. Recognize that the drivers may assign seats to promote good order.
7. Do not eat or drink on the buses or vans at any time.
8. Be on time. The buses will not wait for passengers. Assemble before the bus arrives. Do not wait in vehicles or inside homes unless inclement weather is a factor.
9. Do not tamper with any emergency exits.
10. Recognize that all rules pertaining to drugs, alcohol, tobacco, fighting, or weapons on campus also apply to Munroe vehicles.
11. The parent or child should never attempt to chase down a bus. Do not drive after the bus or attempt to board the bus from a different location.

In addition to the loss of riding privileges in using school transportation, no refund will be given for any transportation suspension. All warnings and offenses will be documented and placed in each student's discipline file.

By signing this document, I wholly understand and agree that my children(s) are my responsibility at the time that the Robert F. Munroe Day School delivers such child(ren) to the designated bus stop on its delivery route or before the bus picks up the children from the designated bus stop. Moreover, I wholly and completely indemnify the Robert F. Munroe Day School from any and all liability for any injury or harm that comes to such child(ren) after the students physically exit the bus in the afternoon or before they enter the bus in the morning.

Name(s) of Children Riding Bus

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Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_



### STATE OF FLORIDA School Entry Health Exam

**To Parent/Guardian:** Please complete and sign Part I — Child’s Medical History.

State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

*(Please Print)*

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

#### PART I — CHILD’S MEDICAL HISTORY

**To Parent/Guardian:** Please check answers to questions 1 through 8 below in the column on the left.

*(Please explain any “Yes” answers in the space provided below.)*

1. Yes  No  Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes  No  Any other specific illness or social/emotional or behavioral problems?
3. Yes  No  Any allergies (food, insects, medication, etc.)?
4. Yes  No  Any prescription medication (daily or occasionally)?
5. Yes  No  Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes  No  Any hospitalization, operation, or major illness (specify problem)?
7. Yes  No  Any significant injury or accident (specify problem)?
8. Yes  No  Would you like to discuss anything about your child’s health with a school nurse?

**To Parent/Guardian:** Please explain any “Yes” answers from above.

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**I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.**



\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

#### Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

**To Parent/Guardian:** Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child’s ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____  Health Care Provider: _____ <i>(check one)</i> Optometrist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/>	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____  Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____  Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.



Name of Child (Last, First, Middle)	Birth Date
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**PART II — MEDICAL EVALUATION**

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date:

(Exam must be within one year of enrollment)

\_\_\_\_\_ Month    \_\_\_\_\_ Day    \_\_\_\_\_ Year

Screening Results:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI%: \_\_\_\_\_ B/P: \_\_\_\_\_ Hct/Hgb: \_\_\_\_\_ Lead: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Vision - Without Glasses	Right 20/_____	Left 20/_____	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>	Hearing - Right	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
Vision - With Glasses	Right 20/_____	Left 20/_____	Failed <input type="checkbox"/>			Hearing - Left	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
			Referred <input type="checkbox"/>						

Gross dental (teeth and gums)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	_____	Refer/Tx: _____
Head/scalp/skin	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	_____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	_____	Refer/Tx: _____
Chest/Lungs/Heart	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	_____	Refer/Tx: _____
Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	_____	Refer/Tx: _____
Postural assessment	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	_____	Refer/Tx: _____

**TB risk assessment done**  (Please review Targeted Testing Guidelines listed below.)

This child has the following problems that may impact the educational experience:

- Vision     Hearing     Speech/Language     Physical     Social/Behavioral     Cognitive

Specify: \_\_\_\_\_

This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

*(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)*

Recommendations (Attach additional sheet if necessary): \_\_\_\_\_

(Please Check One)

- This child may participate fully in school activities including physical education.  
 This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) \_\_\_\_\_

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
<input checked="" type="checkbox"/> _____ Name (Please print or stamp)	____/____/____	

**Tuberculosis Targeted Testing Guidelines for Health Care Providers**

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. **Do not record administration of any TB test or related information on this form.**

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.