

**Tallahassee Area Coalition Center of Excellence  
National Achievers Society  
Parent Permission Form**

Student's Name: \_\_\_\_\_

Student's Address: \_\_\_\_\_

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent(s) Contact: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

**Planned Activity: Attending the Florida Education Fund's Annual Brain Bowl Competition and National Achievers Society State Summit - **Thursday, March 22, 2018 thru Saturday, March 24, 2018**  
Lake Buena Vista, Florida**

I grant permission for my child to travel with the Tallahassee Area Coalition Center of Excellence for a planned trip to Tampa, Florida for the Florida Education Fund's Annual Brain Bowl Competition and National Achievers Society State Summit. This trip is scheduled for Thursday, March 22, 2018 thru Saturday, March 24, 2018.

I understand that the charter bus #1 will leave Rickards High School 3313 Jim Lee Road, Tallahassee, FL at 9:30 am and will be returning to the same location at approximately 10:15 pm on Saturday, March 24, 2018. It will then travel to Leon County Schools Administrative Office Complex at 2757 W. Pensacola Street, Tallahassee, FL at approximately 10:45 pm for the final unload.

I understand that the charter bus #2 will leave Leon County Schools Administrative Offices, 2757 Pensacola Street, Tallahassee, FL at 9:00 am and will be returning to the same location at approximately 12:30 pm on Saturday, March 24, 2018. *(This bus is for the Chiles High, Leon High and Lincoln High Black History Brain Bowl Teams)* If one of these teams places 1<sup>st</sup> thru 3<sup>rd</sup> in the competition, I understand that the charter bus #2 will return to Tallahassee, FL at approximately 10:45 pm. *(Parents will be notified on Friday night by the coaches if the teams place)*

I assume all risks and responsibilities associated with his/her participation, to include appropriate medical fees. In the event of medical emergency requiring medical services, I grant permission for my child to be treated by a certified medical technician, licensed physician and/or be taken to and treated by a hospital/other medical facility.

Special Medical Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)