



- North Campus Central Campus WHC South Campus
- Pines Center Weston Center Miramar Central

Chaperone Form

Organization Name: _____

Event: _____

Date(s): _____

Location: _____

Chaperones:

Club Advisor or Lead Faculty/Staff Chaperone Date

Department Supervisor Date

Director of Student Approval Date

Dean of Student Affairs Approval Date



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Notice of Class Absence Due to Activities

Student Name:

Student Number:

Reason for Absence (50 words or less)

Dates of Absence

Permission to make up class work missed during absence.

Sequence Number	Instructor	Approved	Denied	Signature of Instructor

Instructions to students:

1. List the classes by reference number and instructor that you will miss during your absence.
2. Contact your instructor(s) for class assignments and to secure permission to make up class work missed.
3. Obtain the signature of your Club Advisor or Faculty/ Staff Chaperone for the event.
4. Return the completed form to the Director of Student no latter than two weeks prior to the date of absence.

Club Advisor or Faculty/ Staff Chaperone Date



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Permission for Emergency Treatment

Student Name:

Student Number:

I / We hereby authorize the appointed representatives of Broward College to obtain and authorize medical treatment as is necessary to protect the well-being of my child. Including authorization for emergency treatment, anesthesia, and/or surgery as deemed necessary. Further, I/ We do hereby release and agree to hold harmless Broward College and its representatives from any and all claims which may arise from said medical treatment.

Signature of Student

Date

Signature of Parent or Guardian

Date

NOTE: On rare occasions an emergency requiring hospitalization, surgery, and/or other medical treatment develops. Since in some countries/ states students under the age of 21 years of age might not be administered an anesthetic or operated without the written consent of a parent or guardian, we request that the parent of guardian sign this document in order to prevent a dangerous delay in the administration of emergency medical attention.

Emergency medical information:

Do you suffer from any of the following conditions:

Allergies

Asthma

Convulsions

Heart Trouble

Diabetes

Fainting Spells

Bleeding Disorders

Other (_____)

Do you wear:

Contact Lenses

Dentures

Are you currently taking any medications? (Please List)



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Emergency Contact Information

Student Name:

Student Number:

Address: _____

Email: _____

Home Phone: _____

Alternate Phone: _____

EMERGENCY CONTACT:

NAME: _____ Relationship: _____ Home Phone: _____

ADDRESS:

E-MAIL: _____

Alternate Phone: _____

I herby certify that all of the above information given is true and accurate.

Student Signature

Date