

Students Off And Running Field Trip Form 2013-2014

**Students Off And Running
2013-2014
Event Schedule**

Tuesday, September 24th
Team Tryouts #1
Lowes – Santa Clarita

Thursday, September 26th
Team Tryouts #2
Lowes – Santa Clarita

Friday, September 27th
Team Tryouts #3
Golden Valley High School

Sunday, October 27th
LA Cancer Challenge 5K
Los Angeles, CA

Sunday, November 10th
Calabasas Classic 5K
Calabasas, CA

Saturday, November 30th
YogaWorks Flexibility Clinic
Valencia, CA

Saturday, December 7th
Santa Monica – Venice
Christmas 10K
Santa Monica, CA

Saturday, December 14th
SOAR – Jingle Bell 10 Miler and
Holiday Breakfast!
Encino, CA

Sunday, January 12th
Honkers Half Marathon
Anaheim, CA

Sunday, February 2nd
SRLA 18 Mile Friendship Run
Sylmar, CA

Saturday, February 15th
SOAR 20 Miler and Team BBQ
Newhall, CA

Saturday, February 22nd
Mardi Gras Madness 5K Support
Valencia, CA

Saturday, March 8th
LA Marathon Expo & Team Carbo
Load Dinner
Los Angeles, CA

Sunday, March 9th
LA Marathon XXIX
Los Angeles, CA

Post Season Events (optional)

TBD
Down and Dirty Mud Run 5K
Castaic, CA

SOAR Sports Banquet
TBD
Santa Clarita, CA

PARENT'S OR GUARDIAN'S PERMISSION FOR A FIELD TRIP
AND AUTHORIZATION FOR MEDICAL CARE

To Alan Bingham, President of the Santa Clarita Track Club,

_____ has my permission to participate in
(Student's Name)

the following SOAR event:

Los Angeles Marathon XXIX, Sunday March 9th

Departure: **Whole Foods, Valencia 4:00 AM** Return: **Family Pick Up 4:00 PM**

Supervising Adult : Kevin Sarkissian, SOAR Head Coach, (661) 877-7024

METHOD OF TRANSPORTATION

. Bus . Walking
. Private Auto. Other _____

I agree to direct my child to cooperate with directions and instructions of the personnel in charge of the activity.

Parent's or Guardians permission signature

Date

Authorization for medical care & media coverage
Should it be necessary for my child to have medical care while participating in a Students Off And Running (SOAR) event, I hereby give SOAR personnel permission to care for my child and I give permission to the physician selected by SOAR personnel to render medical care deemed necessary and appropriate by the physician. I understand that SOAR has minimal insurance coverage for my child while participating in an SOAR activity. Therefore, any additional cost incurred for such treatment shall be my sole responsibility.

Student's name

Home address

City Zip

Home telephone number

Business telephone of parent

Emergency telephone number

Authorization signature of parent

Date

I agree to allow my child to be included in any media coverage, group or individual photographs or other related activities portraying SOAR.

Please check here if student is on any medication or requires special medical treatment

Please explain:

