CALAVERAS UNIFIED SCHOOL DISTRICT

3304-B Highway 12
P.O. Box 788
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(209) 754-3504

www.calaveras.k12.ca.us

_____ SCHOOL

Student Participation in District-Sponsored Voluntary Field/Athletic Trip
Parental Permission, Assumption of Risk and Medical Treatment Authorization

Student's Name:_____ has permission to participate in the following field trip:

Destination/Nature of Activity:_____
(Please be specific)

Special Instructions:_____

Departure Date:_____ Time:_____ Return Date:_____ Time:_____

Person in Charge:_____ Position:_____

Method of Transportation: _____ District Bus/Vehicle _____Walking _____Parent/Guardian _____Other (Specify)

Health or special needs: Check as appropriate.

_____ My student has no special health needs the staff should be aware of, and no medication is required on the trip.

_____ My student has a special need, and instructions are attached. Number of attached pages:____

_____ Other:

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and emergency transportation considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

I fully understand that participants are to abide by all rules and regulations governing conduct during the trip.

As provided for in California Education Code Section 35330, I agree to waive all claims against the Calaveras Unified School District and hold the District, its officers, agents and employees, harmless from any and all liability or claims, which may arise out of or in connection with my child's participation in this activity. This waiver shall not apply to any occurrences that may arise solely out of the negligence of the District, its employees or agents.

_____ _____ Work Phone ( )_____
Signature (Parent/Guardian) Print Name Home Phone ( )_____

_____ _____ _____
Student's Signature Student's Date of Birth Date

Family Medical Insurance Carrier:_____ Policy Number:_____
(e.g., Blue Cross)

In the event of an emergency, please contact: _____ _____
Name Relationship

Phone Number:_____ _____
Home Work