

AMADOR COUNTY UNIFIED SCHOOL DISTRICT/COUNTY OFFICE OF ED

**STUDENT PARTICIPATION IN DISTRICT-SPONSORED VOLUNTARY FIELD TRIP
PARENTAL PERMISSION, ASSUMPTION OF RISK, AND MEDICAL TREATMENT AUTHORIZATION**

Date _____

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

Location of field trip _____
Purpose of field trip _____
What to wear _____
Money needed _____
Eating arrangements _____

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

Person in Charge: _____ Position _____

Type of Transportation: School Bus/Vehicle Walking Other: _____

Health or special needs: Check as appropriate.

<input type="checkbox"/>	My child has no special health needs the staff should be aware of, and no medication is required on the trip.
<input type="checkbox"/>	My child has a special need, and instructions are attached. Number of attached pages:_____.
<input type="checkbox"/>	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 Amador County 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 which may arise solely out of the negligence of the District, its employees or agents.

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

Student's Signature Student's Date of Birth

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

In the event of an emergency, please contact:

(Name) (Relationship) Work () _____
Home () _____