

WM. S. HART UNION HIGH SCHOOL DISTRICT

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

To the principal of _____ School:
_____ has my permission to participate in the field trip to
(Student's Name) _____

Purpose of Trip: _____

Date _____ Departure Time _____ AM/PM Return Time _____ AM/PM

Supervisor(s) of trip _____

LUNCH ARRANGEMENTS:

___ Student will be at school during lunch.

___ Student should bring sack lunch.

___ Other: _____

METHOD OF TRANSPORTATION:

___ Walking

___ Private Auto

___ Other: _____

___ School Bus / Charter Bus

Driver's Name (Please Print)

Other Information: _____

NOTE TO PARENT / GUARDIAN:

Section 35330 of the California Education Code states in part:

"All persons making the field trip shall be deemed to have waived all claims against the district or the State of California for injury, accident, illness, or death occurring during or by reason of the field trip or excursion."

I give my permission for my student to attend this trip. I agree to direct my student to be cooperative with directions and instructions of the school district personnel in charge of the activity.

(Parent's/ Guardian's Signature)

Date

AUTHORIZATION FOR MEDICAL CARE

Should it be necessary for my child to have medical care while participating in this trip, I hereby give the School District personnel permission to use their judgment in obtaining medical care and ambulance service for the child, and I give permission to the physician selected by the School District personnel to render medical care deemed necessary and appropriate by the physician. I understand that the School District has no insurance covering such medical or hospital costs incurred by my child and therefore, any cost incurred for such treatment shall be my sole responsibility.

Student's Name

Date of Birth

Home Address

Home telephone number

Parent / Guardian Name (Please Print)

Business telephone number - Parent / Guardian

Emergency telephone number

Authorization Signature of Parent / Guardian

Date:

Instructions for special medical treatment: _____