SUMMERVILLE UNION HIGH SCHOOL DISTRICT

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

Date 2-25

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

Destination/Nature of Activity: DAVIS & Sac State
(Please Be Specific, e.g., Concert UCLA)

Special Instruction: $ or lunch
(e.g., Bring sack Lunch)

Departure Date: 2-25 Time: 7 Return Date: 2-25 Time: 5:00 PM

Person in Charge: Atkins Position: GLC School: SHS

Type of Transportation: ☒ District Bus/ Vehicle ☐ Walking ☐ Other:_____

Health or Special needs: Check as appropriate.

	My student has no 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 of dental diagnosis or treatment and hospital care and emergency transportation considered necessary in the best judgement 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 able 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 Summerville Union High 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 all occurrences which may arise solely out of the negligence of the District, its employee or agents.

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

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

Revised: 6-7-05 yellow