

SAN DIEGO UNIFIED SCHOOL DISTRICT

Office of the Superintendent

AUTHORIZATION FOR STUDENT PARTICIPATION
MULTIPLE-DAY FIELD TRIP OR ACTIVITY

I, the undersigned, am the parent/guardian of: _____

a student enrolled in San Diego Unified School District, request and give permission to have my son/daughter, named above, participate in a field trip to:

(Destination) _____

(Dates) From _____ To _____

I understand that participation in this field trip is entirely voluntary. I voluntarily agree to pay all expenses necessary for the above-named student to participate in the field trip, including, but not limited to, the cost of transportation, food, lodging, and such insurance as may be required by the San Diego Unified School District.

I understand that any travel arrangements made through a travel agency are the responsibility of that agency alone.

I am aware of the provisions of the California Education Code Section 35330, which states, in part, that "...All persons making the field trip or excursion 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 further agree that in the event, in the opinion of a duly authorized representative of the San Diego Unified School District, it becomes necessary to procure emergency medical care for the above-named student due to accident or illness, such care may be procured without my further consent. I personally assume responsibility for any costs of such care not covered by insurance.

Executed in the city of San Diego, County of San Diego, State of California, on

Date

Parent/Guardian

Address:

Telephone: _____

(SAMPLE)

MEDICAL FORM

Student's Name _____ Date of Birth _____

Address _____ Telephone _____

Parent/Legal Guardian _____

Parent's Employer _____ Telephone _____

EMERGENCY PHONE NUMBERS

Day Phone _____

Father _____ Mother _____ Friend _____

Evening Phone (other than home) _____

MEDICAL INFORMATION

Medicines in student's possession _____

List any allergies to medications _____

Date of last tetanus shot _____

List any pertinent medical history or chronic medical problems _____

Medical Insurance _____
(Insurance company)

(Name of insured)

(Policy Number)

Signature _____
(Parent/Legal Guardian)

Date _____