

SANTA MONICA MALIBU UNIFIED SCHOOL DISTRICT

(MINOR) 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: **Please read this information carefully before signing the activity acknowledgement form and waiver of liability attached to this form.**

Destination/Nature of Activity: _____
(Please be specific, e.g., Concert at UCLA)

Special Instructions: _____
(e.g., Bring sack lunch)

Departure _____ **Return** _____

Date: _____ Time: _____ Date: _____ Time: _____

Person in Charge: _____ Position: _____ School: _____

Type of Transportation: District Bus/Vehicle Walking Other _____

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 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 further acknowledge that the District does not provide medical coverage for participants in this activity.

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 Santa Monica Malibu School District (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) Print (Name of Parent/Guardian) Date

() _____ () _____ () _____
 Home Phone Work Phone Cell/Pager Phone

 Student's Signature Print (Name of Student) Student's Date of Birth

Family Medical Insurance Carrier: _____ Policy Number: _____
(Example, Blue Cross)

In the event of an emergency, please contact:

 Name Relationship Work Phone ()
Home Phone ()