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

To the Principal of West Ranch High 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 or money
____ Other: _____

METHOD OF TRANSPORTATION:
____ Walking ___ School Bus/Charter Bus
____ Private Auto
_____
Driver's Name (Please Print)
____ Other: _____

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 of 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: _____

_____