

**PUPIL FIELD TRIP PERMISSION SLIP
AND MEDICAL AUTHORIZATION**
(To be completed by parent, guardian or caregiver)

Please complete and return this form to the supervising teacher of the field trip/activity. **No pupil will be permitted to participate in this activity without this form on file.**

_____, Pupil
[Pupil's Name (print)] [Date of Birth]

at Parkmead Elementary School has my permission to participate in the following:

Activity: _____

Destination: _____

Method of Transportation: _____

Departure Date & Time: _____

Return Date & Time: _____

Departure Location: _____

Return Location: _____

MEDICAL AUTHORIZATION

We(I) are (am) aware and acknowledge that any activity covered by this permission slip, by its very nature, poses the potential risk of injury/illness to the individuals who participate. For and in consideration of the opportunity for our (my) child/ward to participate in the activities covered by this permission slip, we (I) do hereby agree as follows:

1. 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.
2. In the event of illness or injury, we (I) consent to all routine and/or emergency medical treatments and/or services prescribed by the attending physician, surgeon, or dentist, and to the administration and performance of all examinations, treatments, anesthetics, operations, and other procedures which are deemed necessary or advisable by the attending physician at the scene and/or at the hospital or other medical facility.
3. That we (I) are (am) solely financially responsible for any cost and/or all indebtedness incurred as a result of any emergency and/or routine medical and/or surgical treatment and services prescribed by the attending physician for my child/ward, including all charges not covered by insurance.
4. To indemnify and hold harmless the District, its officers, employees, agents, representatives, and volunteers from each and every claim or demand made, and each and every liability, action, loss, debt, or damage which may arise by or in connection with, or result from, any routine and/or emergency medical services, or participation or our (my) child/ward in any activities covered by this permission slip.
5. We (I) fully understand that all persons making the field trip or excursion are to abide by all rules and regulations governing conduct during the trip. Any violation of these rules and regulations may result in the individual being sent home at the expense of his/her parent/guardian.

6. If our/my child/ward has a special medical condition and/or physical disability diagnosed by a physician. A description of that medical condition and/or physical disability is attached hereto.

A special note to Parent/Guardian/Caregiver:

1. All medications taken by your child/ward while participating in the activities covered by this permission slip must be prescribed by a physician and registered on this form.

2. All medication prescribed by a physician for your child/ward must be kept and administered by District staff.

3. _____ Check here if your child/ward has a special medical condition that the District should be aware of, and, if medication will be required on the trip concerning this condition.

4. List any medication that your child/ward must take while participating in the activities covered by this permission slip and for each medication listed provide the dosage and reason for the medication:

Name of Medication	Dosage	Reason(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. My child/ward is allergic to the following medications: _____

6. My child/ward is allergic to the following foods, materials, etc.: _____

I acknowledge that I have carefully read this Pupil Field Trip Permission Slip and Medical Authorization Form and I understand and agree to its terms.

Address: _____

Phone No(s): _____ (where I can be reached during this activity)

Emergency contact if I cannot be reached _____

Name

Phone No.

Pupil's Medical Insurance Carrier

Policy Number

Address

Parent/Guardian/Caregiver (please print)

Signature

Date

Note: This form must be kept with the teacher during the entire activity, and a copy must be kept on file at the school site.