

REDONDO BEACH UNIFIED SCHOOL DISTRICT

Office of Instructional Services

STUDENT PARTICIPATION IN DISTRICT – SPONSORED VOLUNTARY STUDY TRIP

PARENTAL PERMISSION, ASSUMPTION OF RISK, AND MEDICAL TREATMENT AUTHORIZATION

Student's Name: _____ has permission
(First & Last)

to participate on Wed., January 10, 2018 – Fri., January 12, 2018 in the following field trip:
(Date of Study trip)

Destination/Nature of Activity: 8th Grade Pali Science Camp
(Please be specific, e.g. Trip to _____ Museum)

Special Instructions: **You will receive an email from Pali Camp to fill out additional forms.**
(e.g. Bring a sack lunch)

Departure Date: Wed., Jan. 10, 2018 Time: 7:00a.m. Return Date: Fri., Jan 12, 2018 Time: 1:30p.m.

Person in Charge: Lisa Veal Position: Principal School: Adams Middle School

Type of Transportation: School 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 emergency 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 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 Redondo Beach Unified 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.

Wk#/Cell#

Signature of Parent/Guardian

Please Print Name

Hm#

Signature of student

Student's Date of Birth

Medical Insurance Carrier e.g. Blue Cross

Policy Number

In the event of an emergency, please contact:

Wk#/Cell#

Name

Please Print Name

Relationship

Hm#