WM. S. HART UNION HIGH SCHOOL DISTRICT
PARENT'S OR GUARDIAN'S PERMISSION FOR A **FIELD TRIP OR JOB SHADOW**
AND AUTHORIZATION FOR MEDICAL CARE

Please mail or fax or email to Sue Reynolds (sreynolds@hartdistrict.org) at the WSHUSD District Office, 21380 Centre Pointe Parkway, Santa Clarita CA 91350, Phone: 661-259-0033, Fax: 661-254-8653

To the principal of ______________________________________ School

____has my permission to participate in the field trip to (Student's Name – please print), at:

Company Name: ____.

Date: ______________________ Departure Time ___________ AM/PM Return Time ___________ AM/PM

Supervisor name at job shadow site (Please print carefully):

____

METHOD OF TRANSPORTATION:

_____Walking _____School Bus / Charter Bus
_____ Private Auto _______________________________ Driver's Name (Please Print)

_____ Other: _______________________________

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 or 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 child to attend this job shadow. 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.

____
Home Address

____
Home telephone number

____
Parent/Guardian Name (Please Print)

____
Business telephone number – Parent/Guardian

____
Emergency telephone number

____
Authorization Signature of Parent/Guardian

DATE: ______________________________

____
Print Students Name Date of Birth
Instructions for special medical treatment: ____

____