PARENT PERMISSION FOR SCHOOL-SPONSORED ACTIVITY
AND CONSENT TO MEDICAL TREATMENT

Please complete both top and bottom of form: SCHOOL ____________________________

(Name of Student) ___________________________________ has the opportunity to participate in a school
activity away from school premises. If you approve the following arrangements, please sign at the bottom of this section and
return this form to the faculty sponsor.

NATURE OF ACTIVITY ______________________________________________________

DESTINATION _______________________________________________________________

DATE __________ TIME OF DEPARTURE _______ DATE/TIME OF RETURN ___________

TRIP SUPERVISOR ____________________________________________________________

MEANS OF TRANSPORTATION: (Sponsor please check)

A. District-owned bus ____________________________

B. Commercial (Name of company) ____________________________

C. Other (Specify) ______________________________________

I understand the nature of the school activity in which my son/daughter will be participating and that he/she is expected to abide
by all school regulations during the course of the activity.

I understand that, pursuant to Education Code §44808, the district is liable or responsible for the conduct or safety of my
son/daughter only while he/she is or should be under the immediate and direct supervision of an employee of the district.

I hereby give my permission for him/her participate in the above-described activity.

I further agree that, in the event of accident, illness or any other circumstance requiring medical treatment, such treatment may
be procured for my son/daughter without financial obligation to the district.

Date: __________________________ Signature Parent/Guardian ______________________

IMPORTANT MEDICAL INFORMATION THE SUPERVISOR SHOULD KNOW:

________________________________________________________________________

________________________________________________________________________

EMERGENCY TELEPHONE NUMBERS ____________________________________________

THIS FORM SHOULD BE KEPT BY THE CHAPERONE DURING THE ACTIVITY.

(Please complete form below)

AUTHORIZATION TO TREAT A MINOR

I (We), the undersigned parent, parents or legal guardian of ____________________________________________

a minor, do hereby authorize and consent to any X-ray, examination, anesthetic, medical or surgical diagnosis and treatment and
emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any
member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the
staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of
Public Health. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient,
but that any of the above treatment will not be withheld if the undersigned cannot be reached.

This authorization is given pursuant to provisions of Section 25.8 of Civil Code of California.

Date __________________________ Signature of ______________________________________

Father and/or Mother, or Guardian

Allergies to Drugs or Foods ______________________________________________________

Date of Last Tetanus Toxoid Booster _____________________________________________

HS-7 PLEASE COMPLETE BOTH TOP AND BOTTOM OF FORM.