LAS VIRGENES UNIFIED SCHOOL DISTRICT
STUDENT PARTICIPATION IN DISTRICT-SPONSORED VOLUNTARY FIELD TRIP
PARENTAL PERMISSION, ASSUMPTION OF RISK, AND
MEDICAL TREATMENT AUTHORIZATION

Date _____

Student's Name: _____ has permission to participate in the following field trip:

Destination/Nature of
Activity_____
(Please be specific, e.g., Concert at UCLA.)

Special Instructions: _____
(e.g., Bring sack lunch.)

Depart Return
Date: _____ Time: _____ Date: _____ Time: _____

Person in Charge: _____ Position:_____ School: _____

Type of Transportation: ☐ District 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 Las Virgenes 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.

_____ _____ Work Phone ( )_____
Signature (Parent/Guardian) (Please Print Name)
Home Phone ( )_____

_____ _____
Student's Signature Student's Date of Birth

Family Medical
InsuranceCarrier:_____PolicyNumber:_____
(e.g., Blue Cross)

In the event of an emergency, please contact:

_____ _____ Work ( ) _____
(Name) (Relationship)
Home ( ) _____

The student named on the reverse of this form, who is in your class, must have signatures from his/her teachers in order to be allowed to participate in the field trip indicated.

Teachers, please sign authorizing that this student has enough academic and/or behavior integrity to attend. Thank you.

All Teachers Must Sign:

Zero Period_____

Period 1_____

Period 2_____

Period 3_____

Period 4_____

Period 5_____

Period 6_____