White Settlement
INDEPENDENT SCHOOL DISTRICT

Acknowledgement of Responsibility and Permission For Student Participation in Field Trips

Student Attending Field Trip: _____

Parent/Guardian's name: _____

Field Trip: _____ Date: _____ Time: _____

I agree to allow my child to attend the field trip described above.
I understand that while student safety is a high priority for White Settlement Independent School District, under state law, the school is not responsible for medical costs associated with a student injury.
I waive all claims for medical expenses, loss of services, or other claims; and I agree to indemnify and hold harmless White Settlement ISD, its trustees, employees, and agents from all claims made against it or them on behalf of my child.
I agree to indemnify and hold harmless White Settlement Independent School District, its trustees, employees, and agents from all claims made by third parties against it or them which result from my child's actions on the trip.
I understand that White Settlement ISD, its trustees, employees, and agents are not waiving any sovereign or governmental immunity, which it or they have under Texas Law.
I have read and understood this release and sign it voluntarily and with full knowledge of its significance.

Parent/Guardian Signature: _____ Date: _____

Parent /Guardian Daytime Phone: _____

AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT OF A STUDENT

Name of Student attending field trip: _____ Grade: ____ Date of Birth: _____

Parent/Guardian Names _____

Daytime Phone _____ Other Phone _____

Daytime Phone _____ Other Phone _____

Home Address: _____

I hereby authorize the Superintendent of White Settlement ISD or a designated representative to secure any and all emergency medical care and treatment for my child listed above for acute illness suffered or injury sustained while at school or participating in school-related activities. I prefer that emergency treatment be secured at the preferred medical facility listed below. The District may use another licensed hospital, clinic, or medical facility if necessary. I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the District or any of its officers or employees.

I ◯ **do not have** ◯ **do have** medical insurance coverage on my child with the company listed below.

Preferred medical facility: _____ Insurance Company: _____

Parent/Guardian Signature _____ Date_____