POMONA UNIFIED SCHOOL DISTRICT (DISTRICT)
800 SOUTH GAREY AVENUE
POMONA, CA 91766

STUDENT PARTICIPATION IN 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., Concern at Norwalk-LaMirada Arts Center)

Special Instructions/Information: ____
(e.g., Bring sack lunch)

Departure
Date:_____________________ Time:____________(AM/PM)

Return
Date:______________________ Time:____________(AM/PM)

Person in Charge:_______________________________Position:______________________School:________________________

Type(s) of Transportation
❑ School Bus/Vehicle ❑ Walking ❑ Other_____________________________________

Health or Special Needs: Check ✔ as appropriate

	My student has not 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 are: _______ ← ***insert #***
	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 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 District and hold the districts, its board members, 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.

_______________________________ _____________________________
Signature Parent/Guardian Print Name Parent/Guardian

Work Phone (____)_______________
Home Phone (____)_______________
Cell Phone (____)_______________

Date Signed:_________________________

_______________________________ _____________________________
Student's Signature Date of Birth (MM/DD/YR)

Family Medical
Insurance Carrier:____ Policy Number:____________________
(e.g., Blue Cross, Kaiser, Aetna, etc.)

In the Event of Emergency Contact:

_______________________________ _____________________________
Signature Parent/Guardian Print Name Parent/Guardian

Work Phone(____)_______________
Home Phone(____)_______________
Cell Phone (____)_______________