

STUDENT

WALNUT VALLEY UNIFIED SCHOOL DISTRICT

**STUDENT PARTICIPATION IN VOLUNTARY FIELD TRIP
PARENTAL PERMISSION & MEDICAL TREATMENT AUTHORIZATION**

(Student's Last Name) _____ (Student's First Name) _____
has permission to participate in the following Field Trip:
Destination: Great Oak HS Date(s) of Trip: 3/16/24
Special Instructions: _____
Time of Departure: 3:30 PM Time of Return: 11:00 PM
Leaving From: DBHS Returning To: DBHS
Type of Transportation: Bus

TO BE COMPLETED BY: PARENT/GUARDIAN:

Health or Special Needs: Check as appropriate.

<input type="checkbox"/>	My child has NO special needs the staff should be made aware of, and NO medication is required on the trip.
<input type="checkbox"/>	My child has a special need and instructions are attached.
<input type="checkbox"/>	Other: _____

Release and Covenant Not to Sue

We the undersigned, for himself and personal representatives, assigns, heirs, and next of kin, as well as for any minor for whom this Release and Covenant Not to Sue is executed, or that minor's personal representative, assigns, heirs and next of kin, hereby RELEASES, WAIVES, DISCHARGES, AND COVENANTS NOT TO SUE the Walnut Valley Unified School District, its agents or employees, or the State of California for any injury, accident, illness or death occurring during or by reason of the field trip or excursion that is the subject of this authorization (Education Code Section 35330), including any injury, accident, illness or death resulting from the negligence of the Walnut Valley Unified School District, its agents or employees, or the State of California.

The undersigned acknowledges that the field trip or excursions addressed by this release is completely VOLUNTARY. Attendance is not required by Walnut Valley Unified School District or any of its agents or employees.

In the event of any illness or injury, I hereby consent to whatever x-ray, medical treatment authorization, anesthetic, medical, dental, or surgical diagnosis and/or treatment and hospital care from a licensed physician and/or surgeon as deemed necessary for my child's safety and welfare. It is understood that the resulting expenses will be the responsibility of the parent/guardian.

Parent/Guardian Signature _____ Parent/Guardian Print Name _____ Date _____
Work Phone: (____) _____ Home Phone: (____) _____
Student's Date of Birth: ____/____/____
Student's Signature if 18 or over, or if emancipated minor _____
Medical Insurance Company: _____ Policy Number: _____
(e.g. Kaiser)
If Parent/Guardian is not available, please notify:
(Name) _____ (Relationship) _____
Home Phone: (____) _____ Work Phone: (____) _____

DISTRIBUTION: White -- Teacher; Green -- School Site; Canary -- Parent/Guardian