

Last Name, First Name

TORRANCE 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: **West High Entertainment Unit East Coast Performance Tour**
New York, NY, Philadelphia, PA, Washington, DC

Departure Date: **November 20, 2010**

Return Date: **November 28, 2010**

Person in Charge: **Vince Banim** Position: **Teacher** School: **West High**

Type of Transportation: School Bus Walking Other: **Bus, Commercial Airline**

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 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 regulation governing conduct during the trip.

As provided for in California Education Code Section 35330, I agree to waive all claims against the Torrance Unified School 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.

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

Home Phone () _____

Student's Signature Student's Date of Birth

Your medical insurance carrier: _____ Policy #: _____

In the event of an emergency, please contact:

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